EXAMINING THE COMMUNITY HEALTH NEEDS OF BHUTANESE REFUGEES IN THE UNITED STATES

A Dissertation

by

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ABSTRACT

Refugee health is a significant public health concern in the United States due to existing disparities and limited access to health information and health promotion programs. The goal of the dissertation research was to better understand the health situation of a rapidly growing population of Bhutanese refugees and to make recommendations to improve their wellbeing. Three studies were conducted to accomplish this goal: 1) a systematic literature review examining health studies of Bhutanese refugees in the United States 2) a qualitative analysis of health experiences of Bhutanese refugee groups in Worcester, Massachusetts, and 3) program recommendations based on community perspectives of this Bhutanese refugee group. A systematic review on existing literature on Bhutanese refugee health studies in the United States yielded eleven studies which either examined risks, barriers, and health perceptions, or aimed to implement a program targeted to improve health conditions of Bhutanese refugees. The systematic literature review gave insight to specific gaps in knowledge and intervention strategies for health research in Bhutanese refugees. Next, four focus groups and semi-structured interviews were conducted with Bhutanese refugee community members and leaders from August to November 2016 in Worcester, MA. Data analysis revealed that major health barriers stemmed from traumatic history with health care; institutional and social barriers to health; and cultural conceptualizations and stigmatization of prevalent health issues. The participants also offered recommendations to address the barriers they identified. This included

recommendations to increase access to relevant health information and education, utilize existing social support from the community, implement community health discussion groups, and to initiate the training and employment of community health advocates. Findings demonstrated that community engagement is essential in developing health programs. Integration of cultural awareness, community structure, and adequate representation and advocacy in refugee or other vulnerable groups must be considered when implementing public health programs. Future research on vulnerable groups should consider the multifaceted barriers which are faced to implement appropriate methodology for community health development.

DEDICATION

To my husband and my mother, both who have continuously and unconditionally supported me throughout every step of this process. Also, to my son; I hope to always set a good example for him and show him that he can achieve his dreams.

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TABLE OF CONTENTS

Page

Page

Page

LIST OF FIGURES

Page

LIST OF TABLES

Page

CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

Introduction

In the past few years, the global population of individuals who have been forcibly displaced from their countries of origin has reached a record high of over 65 million (United Nations High Commissioner for Refugees [UNHCR] Global Trends, 2015). Among those who have been displaced, almost 22 million are refugees, with close to 2 million new refugees losing their homes in 2015 alone (UNHCR Global Trends, 2015). Refugees become displaced due to a variety of factors such as violence, war, and political, religious, or ethnic conflict or persecution (Im & Rosenberg, 2015; Ott & Montgomery, 2015). The definition of a refugee which continues to be widely used was established by the 1951 United Nations Convention describes a refugee as:

> Any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to avail himself/herself of the protection of that country (UNCHR, 1995).

After being forced to flee their country of origin, usually without warning or advanced notice, refugees then reside in a host country where many live indefinitely in refugee camps or other poorly constructed shelters (Ott & Montgomery, 2015). If the host country is proven to be unsafe or otherwise problematic, refugees are then transferred to

a different country through the process of resettlement (Ott & Montgomery, 2015). Most countries that assist with resettlement are developed nations such as the United States (with the largest number of resettled refugees), followed by Canada, Australia, and various countries in Northern Europe.

While resettlement to developed nations can provide considerable benefits for refugees, many refugee groups still encounter structural and social barriers in their new country following resettlement (Edberg, Cleary, & Vyas, 2011; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Refugees are faced with a different language, customs, norms, and cultural practices. This can be a difficult transition, especially after multiple instances of displacement which often involve surviving traumatic events over a long period of time. In addition, many refugees in the United States encounter various barriers to health which could potentially result in difficulty navigating the complexities of the US health care system, which include: issues of insurance costs and coverage, transportation problems, low English proficiency, lack social support, and limited knowledge of health and health services (Morris et al., 2009).

Refugee Health in the United States

Refugees, like other foreign-born groups in the United States, are likely to live in poverty, low socioeconomic conditions, and have low levels of health literacy (Edward & Hines-Martin, 2015). Additionally, after suffering from various types of trauma from what is sometimes a lifelong process of forced migration and resettlement, refugees continue to be more at risk than other migrants for serious physical and mental health problems (Nelson-Peterman, Toof, Liang, & Grigg-Saito, 2015). Physical health

problems can include chronic diseases and illnesses such as diabetes, certain cancers, obesity, and communicable disease (Nelson-Peterman et al., 2015). The poor conditions of refugee camps and the lack of adequate health care access due to factors such as discrimination or insufficient resources in the camps can contribute to health conditions being overlooked or untreated (Im & Rosenberg, 2015; Lamkaddem, Essink-Bot, Deville, Gerritsen, & Stronks, 2015). Mental health problems can result from the unique health problems related to resettlement process, which include post-traumatic stress disorder from experiences in refugee camps and the conditions of forced migration, in which many refugees have suffered torture, violence, and separation from families (Mitschke, Aguirre, & Sharma, 2013).

Refugees are also less likely than other migrants to use health care services, which can worsen pre-existing conditions over time (Fang, Sixsmith, Lawthom, Mountian, & Shahrin, 2015). For example, discrimination from social and health care institutions towards refugee groups in their resettled host countries can be detrimental to the health well-being of these vulnerable groups (Grove & Zwi, 2006; Segal & Mayadas, 2005). The negative feelings associated with migration may also affect personal health behavior, such as fear of being hospitalized, feeling mistrust towards providers, and being perceived as unwelcome by the host country (Drummond, Mizan, Brocx, & Wright, 2011; Grove & Zwi, 2006; Lamb & Smith, 2002).

Currently, refugee health is becoming increasingly recognized as significant public health issue, as the unequal access to healthcare has led researchers to try to gain better insight on ways to improve health in these communities (Fang et al., 2015; Grove &

Zwi, 2006). A public health approach with ecological perspective to refugee health can provide a deeper insight into the social context to refugee health inequalities; it also offers potential solutions to improve refugee health in their communities.

A Brief History of Bhutanese Refugees

One of the largest groups of the newly arrived refugees to the US are the Nepali-speaking Bhutanese, who represented 26% of resettled refugees in 2011-2012 (Mitschke et al., 2013; Vang & Mong Trieu, 2014). These refugees originated in the country of Bhutan, and were resettled after living in refugee camps in Nepal. Bhutan is a predominately Buddhist landlocked country near the Himalayas; it borders China and India, with Nepal as a neighboring country.

Most of the Bhutanese refugees living in the United States are of Nepali ancestry, and originally migrated to Bhutan in the late 1800s (Evans, 2010). While they began as agricultural migrant workers in Bhutan, over time, they established citizenship, homes, and permanent lives and remained in Bhutan for several generations (Vang & Trieu, 2014). Also referred to as *Lhotshampas* ("people of the south") this group became one of the largest ethnic minorities in Bhutan, and retained their Nepali language, culture, and Hindu religious practices. In the 1980s, the Bhutanese "One Nation, One People" policy was implemented, which was a government attempt to solidify the nation by uniting the people under a single Bhutanese identity (Hutt, 2003).This ruling favored the northern Bhutanese, the dominant culture of the country, and was particularly detrimental to the *Lhotshampas,* who became perceived as a threat to local Bhutanese culture and way of life (Hutt, 2003).

The "One Nation, One People" policy prohibited other groups, such as the *Lhotshampas*, from wearing their traditional clothing and speaking or teaching the Nepali language (Hutt, 2003; Maxym, 2010). This policy also contributed to immigration and citizenship regulations becoming increasingly restrictive by the government. For example, citizenship was stripped from those who could not obtain certain tax documents from 1958, as well as from those who protested or otherwise resisted the policy, making most *Lhotshampas* illegal residents by the early 1990s (Vang, 2015). Hutt (2005) observes that "many *Lhotshmapas* saw [the new citizenship legislation] as an initiative designed to reduce the size of the ethnic Nepali population of Bhutan" (p. 46). Peaceful protesters and public demonstrators fighting for political, cultural, and human rights, as well as advocating for a democratic nation, were deemed "anti-nationalists" and/or "terrorists," imprisoned indefinitely, and often subjected to torture (Hutt, 2005; Vang & Trieu, 2014). By the mid-1990s, over 100,000 *Lhotshampas* were forcibly removed or fled Bhutan to seek refuge in other countries, with the majority settling in Nepal.

Though the *Lhotshampas* were ethnically and culturally Nepali, they were not given citizenship rights upon arrival as refugees in Nepal, and instead lived in impoverished conditions in refugee camps in Eastern Nepal from the early 1990s to the mid-2000s. The volatile political climate of Nepal, as well as the lack of resources and prioritization of the Bhutanese refugees also contributed to the stagnant position of the refugees, who were unable to experience any kind of social mobility or political rights (Vang & Trieu, 2014). Since the political issues were not resolved, and without any hope

of reparation, recognition, or resolution from Bhutan's government regarding the *Lhotshampas,* many were never able to return back to their homes in Bhutan again. The plight of the *Lhotshmapas* (hereafter, "Bhutanese refugees") eventually gained attention from the United Nations, which implemented one of the largest resettlement programs in 2007 (International Organization for Migration [IOM], 2015). The Bhutanese refugees were transferred to developed nations around the world (including the United States, Canada, Norway, Australia, Sweden, New Zealand, Denmark, and the Netherlands) with the majority of 80,000 being resettled in the United States as of 2015 (IOM, 2015).

Bhutanese Refugees in the United States

Since the Bhutanese refugees were removed from their homes multiple times (both Bhutan and Nepal), they have had to consistently readjust to new cultures and lifestyles, which can contribute to additional stress beyond those experienced by many other migrants (Hutt, 2003; Mitschke et al., 2013; Yun et al., 2015). Similar to other refugee groups, this can make them increasingly at risk for poor physical and mental health outcomes (Im & Rosenberg, 2015; Lamkaddem et al., 2015). In the United States, Bhutanese refugees were especially susceptible to mental health issues and suicide, which has been a growing concern on national levels for this group (Centers for Disease Control and Prevention [CDC], 2013). Additionally, since Bhutanese refugee resettlement only began within the past decade, this group has limited resources tailored to their specific community and may have less social ties to outside communities, which could significantly impact their health (Gaertner et al., 1999; Mitschke et al., 2013). Social isolation and lack of availability of culturally sensitive health services have been

risk factors for health disparities and unequal access to care among these groups (Hagaman et al., 2016; Mitschke et al., 2013).

While Bhutanese refugees reside in various states throughout the US, over two thousand (as of 2010) currently live in Worcester, Massachusetts (Fabos, Pilgrim, Muinate, Krahe, & Zack, 2015),. Worcester is located in central Massachusetts with a population of almost 185,000 in 2014 (US Census QuickFacts, 2014). Overall, the economic conditions surrounding the city of Worcester are much poorer compared to the rest of the state, as Worcester has a 22% poverty rate, which is almost double of the state of Massachusetts (US Census QuickFacts, 2014). The poverty status for foreign-born residents is even higher, at around 26% (US Census QuickFacts, 2014). Additionally, the median household income is a little over $46,000 which is significantly less than the state average of $68,000. Research has demonstrated that living with a low socioeconomic status and poverty-stricken conditions can directly affect an individual's health and well-being due to the overall limited accessibility to goods and services (Hammen, 2003; Holzel, Harter, Reese, & Kriston, 2011; McLaughlin, 2011). Additionally, poor housing, violent or unsafe neighborhoods, and financial insecurity can influence physical and mental health, which in term lead to chronic illness and depression, especially among minority women (Belle & Doucet, 2003). Moreover, populations living in low SES conditions may not have the knowledge needed to recognize signs and symptoms for physical and mental health problems, and without an appropriate diagnosis they may never get the help they need (Phelan, Link, & Tehranifar, 2010). Individuals in low socioeconomic status may lack basic necessities

such as running water, healthy food, and resources to deal with potentially serious health issues (Phelan, Link, & Tehranifar, 2010). The social and economic conditions surrounding Worcester contribute to the individual and community levels of risk for poor physical and mental health. Since Worcester in particular is the largest refugee resettlement city in the state, the health status of refugees living in poor economic conditions affects thousands of individuals. Research focused on health perceptions of Bhutanese refugees in Worcester is extremely limited.

Understanding the barriers to good health can improve the community's physical and mental health status through program recommendations based on direct community input. While research on Bhutanese refugees in the United States has been growing in the past few years, little is known about the Bhutanese refugee community in Central Massachusetts, and few studies have incorporated a community-focused, public health perspective on the understandings and perceptions of health of this marginalized group.

Theoretical Framework

The primary theoretical framework for this study is the social ecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988) and the community health development approach (Burdine, McLeroy, Blakely, Wendel, & Felix, 2010). By drawing upon these frameworks, it is possible to better understand the multiple levels of influence on individual health. Additionally, this approach can be utilized to incorporate community input to guide program planners to implement relevant interventions in this community, which can effectively improve the overall health of the community.

Social Ecological Model

A social ecological perspective can be used to understand an individual in the context of the larger social structure, and how their health both influences and is influenced by certain individual and environmental factors (McLeroy et al., 1988, Stokols 1996). Additionally, a social ecological perspective can be useful in establishing a deep, multifaceted understanding of health problems affecting a community so that effective programs can established based on what is often a complex array of health needs in a community (McLeroy et al., 1988; Stokols, 1996).

In the social ecological model, behavior is influenced by multiple and interconnected factors and processes. The levels influencing health behavior include intrapersonal, interpersonal, organizational, community, and public policy levels (McLeroy et al., 1988). The intrapersonal level are factors which are individual level characteristics, including beliefs, attitudes, skills, and personal history. Interpersonal influences include formal and informal social groups and networks such as family members, friendships, and other close relationships. Institutional or organizational factors include social institutions and worksite characteristics influencing health outcomes. Community factors are the existing relationships and connections found among institutions, informal networks, and organizations, as well as neighborhoods, and other "important sources of social resources and social identity" (Mcleroy et al., 1988). Public policy refers to rules, laws and regulations and the local and national levels. Examining these levels allows researchers to better understand health problems which may be affected by internal beliefs (intrapersonal), relationships with others

(interpersonal), or a product of the social or physical environment (institutional and community). On a broader scope, the laws and regulations over an individual or a community may also need to be addressed (public policy), and interventions would have to be implemented accordingly.

One advantage of the social ecological framework is that it emphasizes the role of the individual as an active agent in shaping the environment, policies, and practices in their communities. In turn, this can help affect the social and cultural norms, as well as policy and regulations of the targeted community. The interrelatedness of the various levels and the reciprocal impact on each other is important to take into consideration in health promotion, since programs which target multiple levels of influence are most likely to produce the high impact of health behavior change (McLeroy, Norton, Kegler, Burdine, & Sumaya, 2003). The social ecological model can be used as an analytical lens to identify barriers and facilitators to health in a community in order to implement changes in health behavior, introduce different strategies for health education and information dissemination, and create lasting positive changes in population health status (McLeroy et al., 1988; Stokols, 1996; Richard, Potvin, Kischuk, Prilic, & Green, 1996; Sallis et al., 2006).

Community Health Development

A community health development (CHD) approach incorporates a social ecological perspective at the local and structural levels to help improve the outcomes of health in the community (Felix, Burdine, Wendel, & Alaniz, 2010). This is accomplished by recognizing social determinants of health at different ecological levels as key in

improving population health in disadvantaged communities (Felix et al., 2010). The CHD approach also emphasizes community participation in the identification of health needs for collaborative problem-solving and the effective implementation of health promotion programs.

In community health development, a social ecological perspective implies taking into account the various levels of influence of health in a community. Community health development targeting change at multiple simultaneous ecological levels is necessary as research has shown the majority of health promotion interventions continue to remain only at the individual level of behavior change, which can limit long-term impact and success of effective health promotion programs (Golden & Earp, 2012). The following sections will address some of the major components of the CHD approach, including social determinants of health, collaborative problem-solving, and building community capacity.

Social determinants of health. Social determinants of health are referred to as "social, economic, and political resources and structures that influence health outcomes" (Baker, Metzler, & Galea, 2005). Particularly in public health, identifying specific determinants which are driving forces behind health inequalities in a given population can help identify leverage points for effective interventions (Stokols, 1996). The CHD approach recognizes social determinants of health as a key factor in population health improvement and can provide public health practitioners with a foundation to prioritize health needs in a community and address significant underlying factors which may be barriers to positive health outcomes (Felix et al., 2010).

Collaborative problem-solving. Collaborative problem-solving aims to empower individuals in the community so that they have control over their resources, assets, and decision-making. It also seeks to connect individuals with other social networks to increase trust and support within their community. Communities utilizing collaborative problem-solving have the advantage of gaining multiple perspectives of local residents and stakeholders at various levels and ready to engage in community development (Minkler, 2012). Ultimately, CHD seeks to implement health interventions to maintain long-term positive community health based on issues that were identified by the community through the collaborative problem solving process. Burdine et al. (2010) observe:

> CHD serves as the strategy to plan, develop, implement, monitor, maintain, and evaluate a community's shared vision for the production of health. It is a managed incremental change process that operates simultaneously at the top level and at the local/grassroots level of community (p.3).

This view illustrates the interrelatedness of the individual, community, and system level health determinants. In this approach, the local participation of community members and organization as well as the policy makers and those in power work closely together with the outcome goal of health improvement of a community (Burdine, Felix, & Wendel, 2007; Burdine et al., 2010; Felix et al., 2010). In order to reach the goal of improving population health, there is also a particular emphasis on building community capacity.

Community capacity. Smith, Baugh Littlejohns, and Thompson (2001) define community capacity as "the degree to which a community can develop, implement and

sustain actions for strengthening community health [which involves] enabling communities to exert greater control over their physical, social, economic, and cultural environments" (p.32). The intention is to build on existing assets of a community in order to further develop skills and capabilities, expand social networks and resources, and maintain a positive health status (Hawe, Lloyd, King, Noort, & Jordans, 2000). Building community capacity is a key component for sustainability of good health, as it takes the unique characteristics of a community into consideration to strengthen self-sufficiency among community members and local partnerships (Burdine et al., 2010; Felix et al., 2010).

Conceptual Framework for Current Study

The figure below (Figure 1) represents a conceptual framework for this dissertation based on the integration of the social ecological model and community health development approach from a public health perspective.

Modified Social Ecological Level	*Associated factors at each social ecological level*	***Community Health Development Action***	*Potential Long-term Public Health Outcomes*
Individual *(traditionally intrapersonal and interpersonal)*	Knowledge, skills, attitudes, perceptions, beliefs	In-depth examination or assessment of social determinants of health for implementation of relevant health promotion programs to increase motivations and actual healthy behaviors	Increased knowledge, awareness, and skills for health access, utilization, as well as confidence and motivation for engaging in preventive practices and healthy behavior
Community *(traditionally community, organizational/ institutional levels)*	Relations within and across social institutions; formal and informal networks	Encourage partnerships and collaborative problem-solving across organizations within and outside of the community	Stronger sense of support from inside and outside the community; community engagement and active participatory role in community health improvement

Figure 1. Conceptual Framework for Current Study: Integration of Social Ecological Model and Community Health Development Approach

Figure 1.
Continued

Modified Social Ecological Level	*Associated factors at each social ecological level*	***Community Health Development Action***	*Potential Long-term Public Health Outcomes*
System Level *(traditionally public policy level)*	Laws, rules, regulations, policies at local and national levels	Inform and guide program planners and policymakers of community health needs and strategies to improve health outcomes	Regulations and programs enacted to provide resources and health services for vulnerable communities (i.e. training programs, health education classes, advocacy)

In this conceptual framework, the social ecological model has been condensed into three dominant levels: individual, community, and system, with the corresponding associated factors at each level in the adjoining column. For each level, there is an example of action taken based on the community health development approach and its principles, followed by potential long-term outcomes for public health. As the individual level includes beliefs, attitudes, skills, and personal history, the action taken towards community health development can be an in-depth examination or assessment of a community's specific social determinants of health in order to implement relevant health promotion programs with the goal of increasing motivations and actual healthy behavior in the community (Felix et al., 2010). The program components are based on the identified health needs and prioritization of the community. The potential long-term outcomes for public health are increased knowledge, awareness, and skills for accessing available health services, increased utilization, and more confidence and meditation for preventive practice and overall healthy behavior changes.

The community level, including relationships among and across social and organizational institutions, as well as formal and informal networks, can be strengthened through community health development actions such as encouragement of partnerships and collaborative problem-solving across these institutions within and outside of the community (Burdine et al., 2007). This can build social networks, connections, and introduce diverse resources into the community. The long-term benefits at the community level are a stronger sense of support both within and outside of the community, increased community engagement and active participatory roles in improving the health of the community.

Finally, while a community health development approach may not directly create new laws or policies, actions from practitioners can include informing and guiding program planers and policymakers of the community's health needs, as well as evidence-based strategies to improve health outcomes based on the major problems identified by communities (Felix et al., 2010). In the long-term, this can greatly influence regulations and programs enacted in the future which are ultimately able to provide resources and increase services for vulnerable communities, such as introducing training programs or health education classes, and advocacy and representation for a disadvantaged or overlooked group at local, state, or national levels.

By incorporating a framework utilizing the existing intertwined principles social ecological model and community health development approach, it is possible to gain a holistic perspective of community health and how it is impacted at multiple levels of society. Both the community health development approach and social ecological

framework recognize the various influences of health, from individual beliefs and attitudes to the broader social structure. These models can be used to conceptualize health issues facing a community and strategize ways in which they can be improved. Gaining the perspective of the community can be particularly valuable in identifying community health needs, understanding the health knowledge of community members, and take steps in providing necessary assistance in developing health programs which are relevant and applicable to their given situation. This can help to build capacity by enabling communities to utilize their existing strengths and resources to maintain a positive health status.

By recognizing the multilevel barriers to accessing health resources, as well as factors which may facilitate positive health in the community, this study will address relevant issues through speaking with the community members and gaining insight into their perspectives of health in their communities. This study will apply the Social Ecological Model (SEM) framework and Community Health Development (CHD) approach by highlighting issues specific to the a particular vulnerable group, the Bhutanese refugee community in Worcester, Massachusetts, and addressing their health concerns. Viewing these issues through a socioecological lens can also help shape future health interventions to prioritize capacity building in communities, improve community strength and empowerment, and work towards long-term sustainability of available resources (Miller & Rasco, 2004). Thus, by examining the existing barriers at various levels faced by refugees in the United States, we are also able to better understand the

context of the Bhutanese refugees as a component within issue of health inequality facing the general refugee population.

Literature Review

Refugee Health Barriers at Various Social Ecological Levels

Refugees face various health barriers in the United States and continue to experience health disparities in the health system. The following section describes the major barriers experienced by refugees at the system, community, and individual social ecological levels to provide a background to the context of the problem of refugee health inequality in different aspects of society. Elements of Bhutanese refugee health will also be briefly described to situate the scope of the problem, with a more in-depth systematic literature review of Bhutanese refugee health in the following chapter (Chapter II).

System level barriers. While there are numerous difficulties in obtaining care at the system level, two of the most common barriers found are 1) difficulties with health care navigation and 2) lack of access or availability to sufficient resources, such as specialty care or continued care for serious conditions (Mirza et al., 2014; Navuluri et al., 2014). Refugees generally arrive to the US in worse health than other foreign born groups (Mirza et al., 2014; Navuluri et al., 2014). Upon arrival, they still need assistance in navigating the health care system. Studies have shown that refugees might hesitate to seek help for health care due to a lack of confidence, skills, or ability to develop high degrees of health care navigation (Haun, Valerio, McCormack, Sorensen, & Paasche-Orlow, 2014; Im & Rosenberg, 2015; Yun et al., 2015).

Health care navigation. The process of health care navigation refers to the "level of skill to navigate in society and in health systems to manage one's health needs" (Haun et al., 2014). Health care navigation includes finding a care provider, understanding insurance coverage and medical claims and billing, finding out how to travel to health facilities, and working with referrals for additional care (Yun et al., 2015). Yun et al. (2015) reported that process is complicated and problematic even for English speaking citizens, and "may be all but insurmountable for immigrants with limited literacy, English proficiency, or prior experience with comparable health systems" (p. 2). Though the US may have more health resources available, refugees can face significant obstacles in the health care system after resettlement which may prevent them from being able to fully access the services available (Morris et al., 2009). Additionally, problems with an adequate number or availability of medical interpreters, difficulty understanding the roles of various healthcare professionals, and lack of sufficient information on maintaining their health can add to the challenges of health care navigation for refugee groups (Asgary & Segar, 2011; Yun et al., 2015).

Access to specialty care. Once in the health care system, it becomes difficult for refugees to have access to resources beyond urgent care. Many refugees are resettled with preexisting conditions or in poor health due to the environment of refugee camps, or are burdened with other kinds of trauma from their initial host country (Fang et al., 2015; Mirza et al., 2014). Continuity of care or specialty care may be needed but unavailable or hard to obtain (Mirza et al., 2014). Without proper treatment, their mental and physical health can worsen and have long-term detrimental effects. It is important to

understand and address barriers at the system level, as the lack of coordination among providers, funding cutbacks, and less prioritization of refugee health can contribute to the overall lack of available resources for refugees seeking health care for serious issues (Ellis et al., 2015; Mirza et al., 2014; Yun et al., 2015).

Community level barriers. At the community level, limited external social networks (connections outside of the immediate community) is a significant barrier facing refugee groups. In addition, lack of cultural awareness or sensitivity within health care services can also deter refugees from seeking care (Asgary & Segar, 2011).

Limited social networks. Social isolation is common among refugee communities, as it can be difficult to adapt to a new society, especially when coming from areas of political conflict, violence, or extreme poverty (Burnett & Peel, 2001). Feelings of loneliness, depression, and anxiety can be further exacerbated by poor social support and limited networks (Burnett & Peel, 2001). Without enough refugee-focused community organizations or opportunities to have contact with members of the host country, these groups may be unable to develop valuable social networks and support (Betancourt et al., 2015; Burnett & Peel, 2001).

Cultural sensitivity. Among foreign-born minority groups, lack of cultural sensitivity in health care or health promotion can include 1) overlooking traditional health practices related to a particular culture or religion, 2) limited language abilities of health providers, or 3) limited or absent ethnically matching health care staff (Brach & Fraserirector, 2000). These issues, along with cultural awareness towards refugees are particularly important due to their unique backgrounds and vulnerabilities to serious

health issues directly related to resettlement and forced migration, such as post-traumatic stress disorder (PTSD) (Watters, 2001). Community trust and collaboration is essential for refugee health as they face various stressors post-resettlement, though programs continue to be limited which take a community-centered approach (Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014)

Bhutanese refugees in particular have a communal culture, and it is a social norm to provide mutual assistance and help others in their community (Yun et al., 2015). Studies have also shown Bhutanese refugees have greater trust towards "bridge builders," community health workers, or other kinds of volunteers from the community that help connect them to health services (Im & Rosenberg, 2015; Yun et al., 2015). Though research has demonstrated that community and social support can improve physical health and mental well-being among Bhutanese refugees, community-focused health interventions are still not readily available to this group (Im & Rosenberg, 2015; Mitschke et al., 2013). Social exclusion of refugee communities present challenges in getting help for integrating into society, which is beneficial for health (Betancourt et al., 2015). The limited number of programs and resources which are culturally sensitive to specific refugee groups and dedicated to long-term resettlement assistance can lead to increased distress and negatively impact the overall health of refugees (Betancourt et al., 2015; Watters, 2001). Additionally, those with low levels of community ties and social support can subsequently contribute to poor physical and mental health (Betancourt et al., 2015; Burnett & Peel, 2001; Watters, 2001).

Individual level barriers. At the individual level, refugees may have stressors related to the process of displacement and resettlement, or limited knowledge and awareness of relevant health-related resources.

Displacement-related stressors. Higher degrees of trauma experienced from a refugee's previous country can lead to more stress post-resettlement (Ellis et al., 2015; Watters, 2001) which can contribute to higher levels of perceived discrimination, symptoms of PTSD (post-traumatic stress disorder) and depression (Betancourt et al., 2015; Ellis et al., 2015). Stigma attached to seeking treatment for both physical and mental health issues may prevent individuals from obtaining care, causing conditions to worsen (Drummond et al., 2011; Nazzal et al., 2014).

Difficulty obtaining employment, living in poverty, and post-migration stress can also contribute to personal feelings of hopelessness, sadness, and anxiety (Kohrt, Maharjan, Timsina, & Griffith, 2012; Mitschke et al., 2013). Moreover, the discrepancy among expectations pre- and post-resettlement can exacerbate depressive or anxious feelings (Betancourt et al., 2015; Burnett & Peel, 2001; Mitschke et al., 2013). Being separated from other family members, experiencing linguistic difficulties and dealing with a new culture and environment can all lead to poor health at the individual level for refugees (Ellis et al., 2015; Hagaman et al., 2016).

Research has demonstrated stress from resettlement have significantly affected Bhutanese refugees' health through their low levels of sense of belonging and feeling as if their lives are a burden on their families and others (Ellis et al., 2015). Depression and suicide among Bhutanese refugees is an ongoing serious concern in the United States, as

the suicide rate for Bhutanese refugees in the US is three times the national average, and more than any other country which hosts resettled Bhutanese refugees (Hagaman et al., 2016; Kohrt et al., 2012). While studies have focused on improving mental health of Bhutanese refugees, it is important to examine the individuals within their social context to get their direct experience and voice. This study aims to understand the multilevel barriers faced by these groups and to explore interventions to improve their health outcomes.

Research Questions

Though refugees experience health disparities as all social ecological levels, there is limited research available on Bhutanese refugees using the social ecological model and community health development approach, and even fewer studies on Bhutanese refugees resettled in Central Massachusetts (home to one of the largest Bhutanese resettlement communities in the state). Based on the limited literature on health information and programs focused on Bhutanese refugees, this dissertation will answer the following major research questions:

1) What is the current health status and the major risk factors in the Bhutanese refugees? What are the existing health promotion programs for Bhutanese refugee groups in the United States? (Chapter II)
2) What are the major health problems and barriers to health care within the Bhutanese refugee community of Worcester, Massachusetts as perceived by local community members and leaders? (Chapter III)

3) What are recommendations given by the community for health promotion programs for the Bhutanese refugees in Worcester, MA? (Chapter IV)

Overview of Methods

Data Collection and Analysis

The major research methods used for this study were a systematic literature review on health programs targeting Bhutanese refugees in the United States, and qualitative analyses of focus group discussions and key informant interviews conducted in Worcester, Massachusetts.

Systematic literature review. The systematic literature review focused on studies on health issues among Bhutanese refugees in the US. This review was conducted due to the limited public health literature on this topic. Previous systematic reviews on Bhutanese refugees only examined the health problems in the context of the refugee camps, which most Bhutanese refugees have left for the past decade. Other studies included Bhutanese refugees as a subset of study populations aimed to improve health, thus making specific Bhutanese refugee health needs difficult to discern. Of the 309 studies identified, 11 studies were ultimately analyzed which fit the inclusion criteria of the review. Articles were carefully synthesized and codified based on patterns in the health studies conducted from the years 2006-2016 focusing on Bhutanese refugee adults in the United States. Data reported focused on major Bhutanese refugee health barriers and can be useful to provide relevant information and guidelines for conducting research within this community and the broader refugee population.

Qualitative data collection. As limited research exists on reporting the perspectives and conceptualizations of health, as well as program recommendations for health improvement by refugee community members, qualitative methods was most appropriate to address this gap in the existing literature. The primary source for data collection was through participant observation, focus groups, and interviews. Participants were recruited until data saturation occurred, in which data and conversations did not provide any additional and unique insight with the inclusion of extra participants (Ulin, Robinson, & Tolley, 2005).

Phenomenology, the approach used for this study, is a valuable strategy for qualitative data collection framework, and allows for voices of marginalized populations to be represented (Lester, 1999). Additionally, phenomenology involves "coming to a possible understanding of an underlying meaning of another person's description of a phenomena" which, in qualitative research, is dependent on "analytical thinking, reflection, and interpretation" (Davidsen, 2013). Such qualitative data collection procedure allows for collection of rich, in-depth information regarding the health behaviors and practices of this underserved group. Few studies applied qualitative strategies to assess and analyze the health situation and general health concerns of Bhutanese refugees in the United States. Tolley, Ulin, Mack, Robinson, & Succop (2016) note that qualitative methods in public health can be an "interactive approach...to stimulate conversation and behavior that will let you enter the culture as its members' guest" (p.75).

To provide potential solutions for the reported health problems, further information was also gathered on program recommendations based on community members' inputs. Community members shared their insight on strategies to improve health outcomes based on experiences with health care, prioritizations of health concerns, and available community resources. Ulin et al. (2016) also observe that key informants and participants in interviews or qualitative research are seen as "insiders with special knowledge, status, or communication skills, who are willing to share what they know with the researcher…they are 'the voice of the people of concern'" (p.79).

Qualitative data in this study explored the health experiences of the Bhutanese refugees to gain an understanding of the social context and perceived barriers shared by the community. Utilizing multiple methods of data collection procedures in research, called triangulation, "unquestionably results in a broader perspective on the problem…[and] could increase the credibility of the findings" (Ulin et al., 2005, p.61) . In this study, a combination of memoing, participant observation through time spent with the community, focus groups, interviews, and sociodemographic information questionnaires was used to collect multiple forms of qualitative data. This strategy added to the depth and breadth of available information in order gain a deeper understanding on the perceived problems and barriers to health in the community.

Focus groups. In health research, focus groups can uncover cultural attitudes, characteristics, and reactions to health problems or experiences, and interactions among participants can illuminate broader community perceptions on the issue (Ulin et al., 2016). Krueger and Casey (2015) observe the dynamic interactions of participants in an

environment of mutual support and understanding can help facilitate open dialogue and generate deep insights. Additionally, Ulin et al. (2016) note:

> By stimulating interest in a common problem and listening to others' views, participation can also motivate people to initiate change. As they wrestle with questions posed by the moderator (and sometimes by others in the group) participants' comments and debate among themselves will shed light on their community's wider perspectives, revealing clues to the context, or the social environment, in which individuals make decision that affect their lives (p. 57).

This notion was demonstrated as the focus groups in this study proceeded, participants became more open and receptive in their responses to questions and interactions with each other. When describing their journeys, some realized they were from the same area in Bhutan and discussed mutual contacts. Others were appreciative of having a group where they could communicate their concerns and planned to informally meet again together. This sense of comradery helped keep the focus group members engaged and encouraged sharing stories of problems facing the community that they previously had not considered or known to be a collective issue. In this study, four focused groups with an average of 8-10 participants proved to be sufficient in obtaining data used to thematically code and analyze conversations. This encompassed a total of forty participants and were conducted either in a personal home or communal shared space in the community.

Key informant interviews. Key informant interviews were also conducted to gain additional insight and supplementary perspectives on the health situation of the

Bhutanese refugees in Worcester. In this study, six interviews supplemented the data from the focus groups. Those interviewed were regarded as key persons or leaders who had access to more of the community from within, and several were activists in Bhutan and in Nepal prior to coming to the US. Most of the interviewees, though Bhutanese refugees themselves, also studied or worked for part of their lives outside of the refugee camps. This gave them the advantage of having dual perspectives on the health and experiences of Bhutanese refugees. Additionally, their advanced education and influence led some of them to further their qualifications by obtaining work in the health care industry or the government sector, and all interviewees were utilizing their skills to directly help their community. Data from the interviews was especially valuable as it complemented and highlighted important issues brought forth by the community members and contextualized the current health issues facing the Bhutanese refugees in Worcester.

Data analysis. For data analysis, participants' responses were transcribed verbatim; those which were in Nepali were back translated and also transcribed for data analysis. Through categorical coding and memo-writing, responses were qualitatively coded to develop themes and patterns found in the data. ATLAS.ti, a qualitative data analysis software program was used to identify, code, and categorize common themes.

Study Participants

Participants for this study were recruited primarily through convenience and snowball sampling and through existing contacts with community leaders/ gatekeepers from the Bhutanese refugee community residing in central Massachusetts. Inclusion

criteria for both focus groups and interviews were Bhutanese-Nepali adults (18 years or older) of Worcester and the surrounding areas who migrated to the United States as a refugee and are of Nepali ethnicity. Focus group participants for this study were adult women, with both men and women being included in the interviews. Forty-six participants were included in this study, which was the number reached after obtaining data saturation, when data was no longer adding additional unique insight or perspectives based on the research aims and goals. All participants were given informed consent for audio-recorded sessions and information regarding details of the study. A demographic questionnaire to gather basic information was distributed in the focus groups, with response averages reported in Chapter IV.

Dissertation Overview

The following chapters of the dissertation focuses on the health status of Bhutanese refugees in the United States, and challenges faced in various aspects of their lives which may impede positive health outcomes. After systematically reviewing the existing literature on Bhutanese refugee health, four focus groups and six in-depth key informant interviews were conducted, while also spending time with the community through participant observation. This methodology allowed for a comprehensive, inductive approach to further understand the Bhutanese refugee community health barriers. Findings from data gathered are incorporated in the concluding chapter of the dissertation to provide program and policy recommendations for overall health improvement and well-being in the community.

Chapter II will focus on the first research questions: What is the current health status and the major risk factors in Bhutanese refugee populations? What are the existing health promotion programs for Bhutanese refugee groups in the United States? The purpose of Chapter II is to synthesize and critically analyze existing data in order to identify gaps in the literature and inform areas of focus for future health programs targeting Bhutanese refugees in the United States. The systematic literature review allowed for an in-depth look on published studies pertaining to Bhutanese refugee groups and areas which more research is needed in order to improve and maintain a positive health status among this particular population. In addition, findings also highlight ways other refugee groups can also be affected by common health barriers and suggest strategies to address and positively impact health disparities in larger marginalized and vulnerable minority groups in the United States.

In this chapter, I examine relevant literature related to the health of Bhutanese refugees and organize articles according to the type of study published, namely, descriptive studies and intervention studies. The articles included the review emphasize Bhutanese refugee health in the United States, and major barriers addressed through health outcomes among these groups. The categorizations of different types of studies helped to identify major health risks and barriers to health services, as well as potential strategies to alleviate health risks based on the study approach and health problems emphasized. This data were also used to connect specific issues with broader implications for refugee health programs. The findings from the systematic literature

review were used to guide and shape the focus group and interview questions for the remainder of the study.

Chapter III will focus on the second research question: What are the major health problems and barriers to health care within the Bhutanese refugee community of Worcester, Massachusetts as perceived by local community members and leaders? The purpose of this chapter was to explore the health experiences of Bhutanese refugees and how their views of health are conceptualized. This research uncovered various barriers to health care access and utilization among these groups based on specific cultural considerations and shared experiences. This chapter utilizes qualitative research methods to explore the experience of Bhutanese refugees with health care services in central Massachusetts. Data analysis in this chapter is based on the conversations obtained through focus groups and interviews with forty-six participants. Results yielded common themes across focus groups and interviews and provide a deeper understanding of how this community conceptualizes health and health care based on their lived experiences.

The major themes in this study are organized and reported through a social-ecological framework addressing system, community, and individual level barriers to positive health in this community. These included past experiences with discrimination in health, institutional barriers from medical interpreters, social and cultural barriers in the community, and shared conceptualizations and stigmatization of sensitive health issues. This study uses the experiences of health among the Bhutanese refugees in Worcester in order to capture the most significant barriers and their contributing factors

which greatly affect refugee health in the community. This allows for a unique view on collective perspectives which have not previously been documented and suggests various ways these issues can be addressed through future research and health promotion activities specifically geared towards the perceived barriers to positive health in the community.

Chapter IV addresses the third research question: What are recommendations given by the community for relevant programs components which may effectively promote health for Bhutanese refugees in Worcester, MA? The purpose of this chapter was to gain community input for strategies to improve overall health in the community. Findings from community input are reported by identifying specific elements which can be incorporated into culturally relevant programs for public health practice aiming to improve the health of Bhutanese refugees. The community was asked to give insight on their specific health needs, which was I then reported and translated into potential program elements for public health promotion among this group. The qualitative data and thematic categories are used to understand the community voices and demonstrate health needs. This data can be used to ascertain various avenues in which public health practitioners can productively intervene and improve health of the population in future program development activities. This research also points to broader implications of necessary considerations of vulnerable and refugee groups which should be taken into account when initially designing and developing tools to put together effective programs into a community which may have been previously ignored or overlooked.

As ethnic minorities in their home countries, and living in poverty in refugee camps, Bhutanese refugees continue to face health disparities after resettlement into the US. Their plight is similar to that of other refugees who predominantly suffer from trauma, political violence, and forced migration, all of which can lead to devastating health consequences. In this dissertation, the health behaviors and perceptions of the Bhutanese community in Worcester, Massachusetts will be examined from a public health perspective to bring necessary attention to a significantly disadvantaged minority group. Special attention will be paid to women in the community and their perceived barriers to health and health care. The experiences of the Bhutanese refugees reflect the growing issue of health inequalities faced by refugees, who continue to suffer through low access to health care, culturally inadequate programs, and limited availability of resources in refugee communities today. This dissertation aims to incorporate a public health approach to understand health issues from the perspective of the community in order to provide information which can improve health outcomes and reduce disparities in an underserved, vulnerable group.

CHAPTER II

BHUTANESE REFUGEE HEALTH IN THE UNITED STATES: A SYSTEMATIC LITERATURE REVIEW

Introduction

There are over 51 million refugees globally who left their countries of origin by force or through fear due to a variety of factors such as violence, wars, and political turmoil, religious persecution or ethnic conflict (Im & Rosenberg, 2015; Ott & Montgomery, 2015). The number of refugees to the United States has been rapidly increasing since the 1960s (Aday, 2002). Refugees are "subject to the highest level of security checks of any category of traveler to the United States" (US Department of State [USDS] , 2017) and undergo a rigorous health and security screening process, medical examinations, and cultural orientation sessions for entry to the US. Refugees are expected to repay the US government for travel costs and are resettled through state department collaborations with domestic nonprofit organizations (USDS, 2017). Food, housing, employment counseling, and other living needs are arranged and provided by private voluntary agencies for the initial 90 days with the expectation of gaining employment within six months (American Immigration Council, 2015). Refugees may apply for Lawful Permanent Resident status after one year, and petition for naturalization after five years (American Immigration Council, 2015).

While refugees are provided with some outside and government assistance in the process of resettlement, this group continues to face challenges and inequalities in

various aspects of their lives, and have been specifically shown to have disproportionately poorer health status than local residents (Lamkaddem et al., 2015). Refugee health has become a major public health concern in the United States due to the increasing number of refugees migrating to the country, many of whom have a history of experiences with trauma from political and ethnic conflict. Migration under hazardous conditions, often coupled with traumatic experiences from surviving the dilapidated state of most refugee camps can make refugees increasingly susceptible to physical and mental health problems including chronic illness, communicable disease, and depression and post-traumatic stress disorder (Im & Rosenberg, 2015; Lamkaddem et al., 2015). The conditions faced after arrival may also contribute significantly to the poor health status of refugees. As a recognized vulnerable population, refugees are at risk for low physical and mental health outcomes due to limited social and economic resources, low literacy levels and social status, and prevalence of mental health problems such as depression and post-traumatic stress disorder from history of exposure to traumatic situations (Aday, 2002)

Inadequate access to health care and health services in most refugee camps can contribute to many serious health problems, which may have been left untreated or overlooked by the time refugee groups arrive to the United States (Vang and Trieu, 2014; Aday, 2002). This can further exacerbate existing health issues or contribute to increased risk of developing additional burdens on health such as comorbidities of physical and mental health disorders and underutilization of health services (Berthold et al., 2014). Additionally, refugee groups may have significant difficulty integrating to a

new life in the US due to social, economic, and cultural barriers (Pace, Al-Obaydi, Nourian, & Kamimura, 2015). Low English proficiency, resettling later in life, and perceived lack of support can contribute to additional stress, and also may limit knowledge of existing health services in the community (Grove and Zwi, 2006; Aday, 2002). After documented experiences of extensive hardship, poor living conditions, and inadequate health care throughout their migration process, health researchers in the US have focused on post-resettlement stressors and ways to improve refugee health (Betancourt, 2011; Grove and Zwi, 2006; Fang et al., 2015).

One of the largest groups of the newly arrived refugee populations to the US are the Nepali-speaking Bhutanese, also known as *Lhotshampas* who represented 26% of resettled refugees in 2011-2012 (Mitschke et al., 2013; Vang & Mong Trieu, 2014) After living in generations as an ethnic minority group in Bhutan, growing political conflict in the 1990s resulted in over 80,000 *Lhotshampas* being stripped of their Bhutanese citizenship and basic rights. These groups were subsequently exiled from Bhutan into contained in refugee camps in Nepal, where families struggled to survive for almost 20 years (Hutt, 2003; Evans, 2010).

Refugee camps are generally constructed to be temporary shelters and consequently have low resources and access to effective care. The length of time the *Lhotshampas* (herein referred to as "Bhutanese refugees") spent in the Nepal refugee camps is significantly longer than the number of years most other refugee groups remain in camps (Vang & Trieu, 2014), thereby heavily increasing their risk to exposure, poor health services, and continued discrimination in health care and treatment. The

Bhutanese refugees were largely overlooked for the decades they resided in the camps until United Nations resettlement programs in 2007 began placing them in developed nations around the world, with the majority being resettled in the United States.

Existing multidisciplinary health research of Bhutanese refugees has found significant barriers to positive health outcomes, including issues of language, untreated mental health disorders, and lack of support from outside of the community leading to social and cultural isolation and difficulty with acculturation (Hagaman et al., 2016; Kohrt et al., 2012; Mills, Singh, Roach, & Chong, 2008). While there have been various programs targeted towards improving the health of Bhutanese refugees, there are limited existing systematic literature reviews addressing these specific studies and their components. Assessing health studies to better understand barriers which may prevent positive health outcomes can help gain deeper insight on necessary action needed to address prominent health concerns in the resettled Bhutanese refugee community in the US. By focusing specifically on Bhutanese refugee groups in the United States, it is possible to narrow specific conditions encountered by these groups in order to improve the overall health of one of largely overlooked vulnerable refugee population. Previous systematic literature reviews and meta-analyses have only looked at Bhutanese refugees in the context of refugee camps in Nepal (Mills et al., 2008; Tol et al., 2010).This study is among the first systematic literature reviews to exclusively address Bhutanese refugee health in the United States from a public health perspective.

Due to the demonstrated need to improve the health of vulnerable groups in the US, particularly that of refugees, this paper aims to systematically review relevant

literature related to the health of Bhutanese refugees in the United States. This study will examine programs which only target Bhutanese refugee participants in order to 1) describe specific elements of health studies, including study design and area of focus, recruitment strategies and population characteristics 2) analyze major findings based on study type, either descriptive or intervention-focused health study 3) provide implications for major health barriers and risks which can be further developed in future research to improve the health and well-being of refugees in the United States. The studies in this review will primarily focus on Bhutanese refugee health, and barriers addressed through health outcomes among these groups.

By examining the effects of research which addresses Bhutanese refugees, this review can guide future research on refugee groups by highlighting important problems which may parallel health burdens of other vulnerable groups, as well as provide implications which can help improve the health of these populations. The research questions guiding this study were as follows: 1) What is the current health status and the major risk factors in Bhutanese refugees? 2) What are the existing health promotion programs for Bhutanese refugee groups in the United States?

Methods

The methodology in this review was developed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (PRISMA) (Moher et al., 2015). Articles included in the current review are articles from peer-reviewed journals. Specific health topics or problems were not restricted to encompass the wide array of health issues which the Bhutanese refugees may encounter.

Additional inclusion criteria were as follows:

1) Articles published within and including the years of 2006-2016 (as Bhutanese refugees began arriving to the United States in early 2007)

2) Studies taking place in the United States

3) Studies which only included adults (ages 18 and older)

4) Studies only focusing on Bhutanese refugees with at least one health outcome

5) Studies which were either qualitative, quantitative, or explanatory (such as health assessments)

Exclusion criteria were the following:

1) Duplicate publications and studies and articles published prior to 2006

2) Articles were which not peer reviewed, such as conference abstracts

3) Articles examining or including children or youth in the study (under age 18)

4) Articles involving to Bhutanese refugees outside of the US

5) Studies which included other refugees in their target population of interest

6) Studies which were retrospective analyses, reviews, or theoretical pieces and

7) Articles with data which was follow-up to, or part of, a different or a larger study.

The databases searched in this review were EbscoHost, OVID, Scopus, MEDLINE (Pubmed); PsycINFO, and Web of Science, with the last search being September 2016. The Cochrane Database for systematic reviews was searched for existing reviews on Bhutanese refugee health studies. To check for publication bias, Google Scholar was also searched. Boolean search strategies were generated and filtered using search terms such as “Bhutanese refugees” AND “health” OR “Bhutanese refugee

health" with "study" OR "program" OR "intervention" OR "study" AND "United States". The reporting flow chart (Figure 2) illustrates the articles retrieved based on inclusion and exclusion criteria.

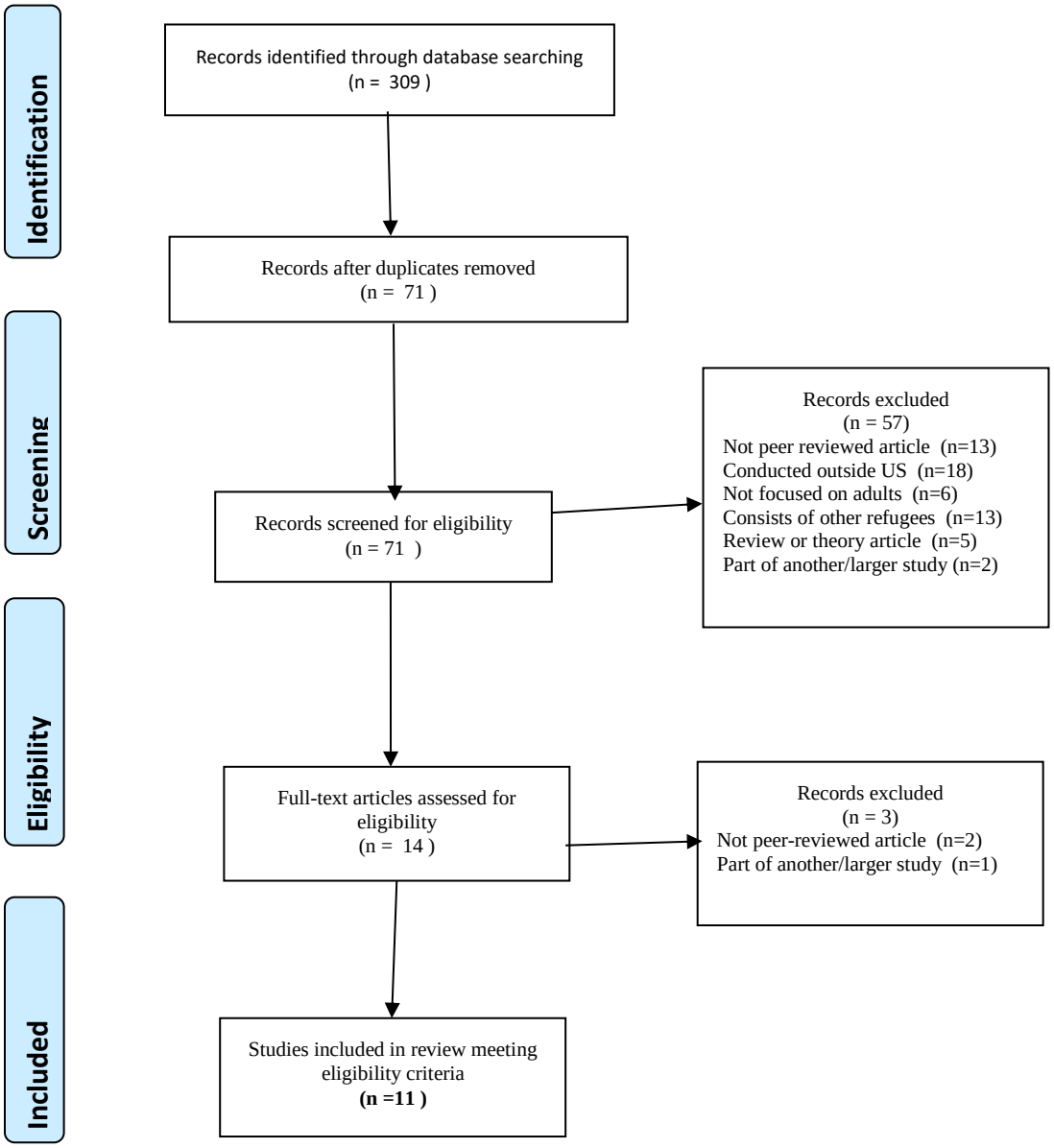

Figure 2. Selection Process for Including Studies in Systematic Literature Review

Results

From the 309 articles retrieved, 238 were duplicate studies and removed from the search. 71 articles were reviewed by screening abstracts, and 57 were excluded based on eligibility criteria. After gathering the remaining 14 articles and screening by full text, 3 additional articles were excluded: 2 were follow-ups to a larger study and one was not a peer-reviewed journal article. In the current review, 11 articles are examined which met inclusion criteria. Data extracted from the included articles were the following:

1) identification of the study,
2) study design and type of study
3) major health problem(s) area of focus and study objectives
4) recruitment and study setting
5) participant characteristics,
6) major study outcomes or results.

Studies were coded by two coders to facilitate consistency of coding and quality of articles meeting inclusion criteria. The coding schema assessed both qualitative and quantitative studies. Following the identification of the type study conducted (or study design, such as cross-sectional survey, focus groups, or health assessment), and study location (only US-based studies were included). Next, after determining the major health problems addressed, a qualitative assessment of the full text of each article assisted in a deeper analysis of the content and characteristics of included articles. This involved study design quality (inclusivity and cultural considerations in recruitment strategy and study setting, and participant characteristics), study outcome or results (including

changes in health status, health behavior changes, or change in available data of target group), and reported implications of identified barriers to health (potential impact of study on health of target group and/or larger population). Consensus was reached for any discrepancies in data analysis, as well as to categorize each study in a corresponding social-ecological level, either individual, community, or system, also accounting for and permitting overlap, or multiple levels applied to one study.

The summary of relevant data used for the analysis is shown on Table 1. Eleven studies were included in the analysis. Though the established time frame for the studies included 2006-2016, all studies were conducted between the years of 2011-2016, with the majority (eight) occurring in 2014 or later.

Table 1.
Summary of Included Relevant Health Studies Focusing on Bhutanese Refugee Health in the United States

Study (Title, Author(s), Year); **Area in US conducted**	**Study Design (Methods)** **Type of study (Descriptive Study or Intervention Study)** **Social Ecological Level (individual, community, system)**	**Major health problem(s) addressed;** **Study objectives**	**Recruitment strategy and study setting**	**Participant characteristics**	**Outcome or results**
Benson et al., 2012; **Southwest US**	Quantitative Descriptive Study Cross-sectional survey design Individual Level	Mental health: acculturation stress Examine relationship between religious coping and acculturation stress	Non-random and snowball sampling from local community; in-person visits. Surveys administered in classrooms within three apartment complexes.	n=112 Female = 38% High school graduate = 27% English proficiency (poor or none) = 54% Time in the US (1 year or less)= 61%	Higher English proficiency, education linked to lower levels of stress Higher levels of religious coping and satisfaction with social support correlated with higher levels of environmental acculturation stress

Table 1.
Continued

Study (Title, Author(s), Year); **Area in US conducted**	**Study Design (Methods)** **Type of study (Descriptive Study or Intervention Study)** **Social Ecological Level (individual, community, system)**	**Major health problem(s) addressed;** **Study objectives**	**Recruitment strategy and study setting**	**Participant characteristics**	**Outcome or results**
Bhatta, Shakya, and Assad, 2014; **Northeast Ohio**	Quantitative Descriptive Study Socio-demographic questionnaire in cross-sectional study Individual Level	Nutrition and chronic diseases Examine Bhutanese refugee women's cultural health and nutrition factors	Snowball sampling from community liaison and her contacts Surveys administered in groups of 8-10 in one of participants' homes	n=120 Female = 100% High school graduate = 8% English proficiency (low) = 49% Time in the US (1 year or less)= 66%	High hypertensions, Overweight/ obesity observed in majority of women studied.
Hagaman et al., 2016; **Various US states**	Quantitative and Qualitative Descriptive Study Face-to-face questionnaire with open ended responses; field notes Community Level	Mental Health Examine social factors associated with suicide	Selective sampling through decadent's close family member or adult contact. Survey administered face-to-face by trained interviewer from the Bhutanese refugee community in participant's home.	(Characteristics of interviewee): n=14 Female= 36% High school graduate = not specified English proficiency (low) = not specified Time in the US (1 year or less) = not specified (Characteristics of decedents) n=14 Female= 36% High school graduate = 36% English proficiency (low) = 50% Time in the US (1 year or less) = 100%	Major factors for suicide reported by interviewees: language barriers, worrying about family back home separation from family, difficulty maintaining cultural and religious traditions.

Table 1.
Continued

Study (Title, Author(s), Year); **Area in US conducted**	**Study Design (Methods)** **Type of study (Descriptive Study or Intervention Study)** **Social Ecological Level (individual, community, system)**	**Major health problem(s) addressed;** **Study objectives**	**Recruitment strategy and study setting**	**Participant characteristics**	**Outcome or results**
Haworth et al., 2014 **Nebraska**	Quantitative and Qualitative Descriptive Study Self-administered questionnaires; focus groups Individual & Community Level	Cervical cancer Assess knowledge, attitudes, and practices for cervical cancer screening among Bhutanese refugee women.	Snowball sampling via community partners Surveys and focus groups administered in convenient community settings and residences, with help from community partners.	n=69 Female= 100% High school graduate = 19% English proficiency (low) = 59% Time in the US (1 year or less) = 47.6%	Limited knowledge and access of pap test and low perceived susceptibility to cervical cancer; Barriers identified as shyness, stigma, and language.
Im and Rosenberg, 2015 **Virginia**	Qualitative Intervention Study Peer-led intervention Community Health Workshop using CBPR Community Level	Physical and mental general health Assess impact of peer-led intervention for health promotion within the Bhutanese refugee community and effect on social capital in peers	Snowball sampling through peer facilitators 8 sessions conducted over 2 month period	n= 22 Female= 82% High school graduate = not specified English proficiency (low) = not specified; low literacy levels mentioned Time in the US (1 year or less) = all lived in US between 1-6 years	Increased knowledge, awareness, and skills for dietary and behavioral health practice and emotional coping. Increased subjective health and perceived social capital for health promotion.
Kiptinness and Dharod, 2011 **North Carolina**	Qualitative Descriptive Study Household observations and semi-structured interviews Individual Level	Nutrition Examine food-related issues and barriers upon resettlement	Snowball sampling through resettlement agency Observation and interviews occurred in household of participant	n=14 Female= 100% High school graduate = 21% English proficiency (low) = 71% Time in the US (1 year or less) = 100%	Barriers identified included higher social isolation, difficulty with transportation, heavy reliance on government assistance for nutritional intake.

Table 1.
Continued

Study (Title, Author(s), Year); **Area in US conducted**	**Study Design (Methods)** **Type of study (Descriptive Study or Intervention Study)** **Social Ecological Level (individual, community, system)**	**Major health problem(s) addressed;** **Study objectives**	**Recruitment strategy and study setting**	**Participant characteristics**	**Outcome or results**
Misra et al., 2014; **Texas**	Quantitative Descriptive Study 60-item survey instrument Community & Individual Level	Physical health and mental health Generate a community health needs-assessment	Convenience sampling, outreach through refugee resettlement agencies and service agencies Participants approached in ESL classes (English as a Second Language) and door-to-door Surveys administered in participants' residences	n=100 Female= 56% High school graduate = 20% English proficiency (low) = not specified Time in the US (1 year or less) = 23%	High blood pressure dizziness and arthritis common chronic health conditions low rates of exercise; moderate healthy food intake
Mitschke, Aguirre, and Sharma; 2013 **Southwestern US**	Quantitative Intervention Study Quasi-experimental using non-equivalent group design Community Level	Mental health assess the impact of a group-based financial education course on the mental health	Convenience sampling Financial literacy class held in community center of apartment complexes of refugee participants	n= 65 Female= 100% High school graduate = 50% English proficiency (low) = not specified Time in the US (1 year or less) = 100%	Decreased post-traumatic stress and depression in intervention group
Subedi et al., 2015 **Pennsylvania**	Quantitative and Qualitative Intervention Study Pre-test post-test design System Level	Mental health Investigate the impact of MHFA (Mental Health First Aid) training program on Bhutanese refugee community leaders '	Recruitment through formal and informal contacts Training conducted in classrooms at nearby University. One bilingual interpreter per class; classes were primarily conducted in English	n=58 Female= 17% High school graduate or higher = 43% English proficiency (low) = 0%; all had high proficiency Time in the US (1 year or less) = not specified	Following intervention, increased knowledge of mental illness, confidence for referrals No change observed in personal and perceived stigma

Table 1.
Continued

Study (Title, Author(s), Year); **Area in US conducted**	**Study Design (Methods)** **Type of study (Descriptive Study or Intervention Study)** **Social Ecological Level (individual, community, system)**	**Major health problem(s) addressed;** **Study objectives**	**Recruitment strategy and study setting**	**Participant characteristics**	**Outcome or results**
Vonnahme, et al., 2015 **Various US States**	Quantitative Descriptive Study Cross-sectional survey Community Level	Mental health Explore depression-related factors and prevalence of mental illness symptoms in Bhutanese refugee community across the US.	Random selection of participants Survey administered in Nepali or English by interviewers in at respondent's place of residence	n=386 Female= 47% High school graduate = 13% English proficiency (low) = 40% Time in the US (1 year or less) = not specified; average 1.7 years	More women reported depression; symptoms were associated with being a family provider, self-reported poor health, and illiteracy level
Yun et al., 2015 **Pennsylvania**	Qualitative Intervention Study Interviews examining patient navigator health program using CBPR System Level	General health behaviors Describe health care access problems, help-seeking behaviors, and program acceptability and adaptability	Recruitment through word-of-mouth Accessible location to community prioritized	n=35 Female= 63% High school graduate = not specified English proficiency (low) = 97% Time in the US (1 year or less) = 19%	Following the intervention, one-third of participants reported high levels of patient activation

Study Location

The location of the studies varied; about half (five) of the studies were conducted in the south or southwest regions of the US, and three were in the northern United States, two in multiple states, and one in the Midwest.

Study Design

Study design and analysis also varied throughout the different studies. Five studies were primarily analyzed quantitatively, three were qualitative, and three were mixed design, using both quantitative and qualitative analyses in their final report. The quantitative studies utilized cross-sectional surveys or self-administered questionnaires, with one study using quantitative analysis for a quasi-experimental non-equivalent group design (Mitschke et al., 2013). Qualitative studies used focus groups or interviews, and direct observation methods and thematically analyzed results. The mixed methods studies used a combination of surveys, focus groups, and interviews. Four studies examined the effect of a health promotion intervention, while the others aimed to assess existing socio-demographic factors, health beliefs, and/or health behaviors of those participating. One study utilized direct observation of dietary habits in the household (Kiptinness & Dharod, 2011). Regardless of the type of study design, participants received face-to-face interaction and interpretation assistance when needed. Participants were administered surveys and questionnaires in person, either at or near the participants' residences.

Types of studies were categorized into 1) descriptive studies or 2) intervention studies. Descriptive studies utilized cross sectional surveys, questionnaires, focus groups, interviews, or observations in order to report health profiles, descriptive analysis or observational characteristics of the target group. Intervention studies were programs or interventions implemented to assess a change in health or health behavior following the study, usually involving a training intervention, community based participatory

research design, or pre-test post-test design. Most studies (seven) in this review were categorized as descriptive.

The study design was also categorized based on the social-ecological level of focus (McLeroy et al., 1988), Three studies occurred at the individual level, over half (six) of the studies examined the health problem of concern at the community level, and two were targeted at a system level. Categorization using the social-ecological levels, though not identified explicitly in each study, helped to specify the level or levels at which barriers can be found.

Major Health Problem Addressed

The studies in this review examined different aspects of health, with the majority (eight) including some aspect of mental health; five focused exclusively on mental health, while an additional three included mental health as a major health problem that was to be addressed in addition to another primary focus. Two focused on nutrition and one addressed cancer prevention. A summary statement for the each study's objective was also noted in this section.

Recruitment Strategy and Study Setting

Studies used snowball, convenience, or nonrandom sampling to gain access to the community, having at least one internal community member as a person of contact, giving researchers access to the larger Bhutanese refugee community. All studies emphasized the need for prioritizing the issue of access and convenience for the study setting, as many of the participants did not have reliable transportation. Eight studies

provided more detailed information about the setting, indicating the participants' home or apartment complex, or a nearby accessible facility as the study location.

Participant Characteristics

Participant characteristics in this review were described by number of those participating in the study (*n*), percentage of female participants, percentage of those holding a high school degree or higher to measure educational attainment, and percentage of those indicating low or limited English proficiency, which was indicated by measurement terms which were primarily self-reported as "low", "poor", "below average", or "none". Additionally, if specified, the percentage of participants who were living in the US for one year or less was also reported.

The number of participants per study varied based on the methodology used. For qualitative studies, the number of participants was between n=14 and n=22. In the quantitative studies, number of participants ranged from n=65 to n=386, and mixed studies participants were n=14 to n=69. Four studies had only female participants, the rest were mixed. Other than one study (Subedi et al., 2015), most participants had low education levels (less than high school), with limited or no English proficiency. Studies that specified duration of residence indicated most participants had lived in the US for only a few years, with the majority being one year or less.

Study Outcomes

The studies in the review sought to assess health characteristics or health behaviors and motivations of Bhutanese refugee groups, or determine the effectiveness of a health program. For studies which utilized interventions, including pre-post test

designs, outcomes demonstrated improved health or health knowledge (Im and Rosenberg, 2015; Mitschke et al. 2013; Subedi et al., 2015; Yun et al., 2015). The remaining studies surveyed participants or generated a community health assessment or profile which gave an in-depth view of major health concerns and areas needing improvement for Bhutanese refugee communities (Benson, Sun, Hodge, & Androff, 2012; Bhatta, Shakya, & Assad 2014; Hagaman et al., 2016; Haworth et al, 2014; Kiptiness and Dharod, 2011; Vonnahme et al., 2015).

Overall Health Barriers

Table 2 reports an analysis of major identified health risks and barriers to health services, as well as potential strategies to alleviate health risks based on the type of study (descriptive or intervention) used in this review.

Table 2.
Summary of Health Barriers and Potential Strategies to Alleviate Health Risks for Bhutanese Refugee Groups in the United States

Type of Study (Descriptive or Intervention)	**Major identified health risks and barriers to health services**	**Potential strategies alleviate health risks**	**References**
Descriptive Study	High rates of heart disease and obesity Mental and emotional stress from acculturation process Low awareness and perception of risk of serious health issues (i.e. obesity, cancer) Low English proficiency	Observe and report health behaviors (i.e. dietary, physical activity) for improved applicable recommendations in community Gain deeper understanding of community through research towards major cultural and social factors contributing to health perceptions to increase health promotion Generate community health assessment or health profile to highlight major risk factors and guide future research	Benson et al., (2012) Bhatta et al., (2014) Hagaman et al., (2016) Haworth et al. (2014) Kiptinness and Dharod (2011) Misra et al. (2015) Vonnahme et al., (2015)

Table 2.
Continued

Type of Study (Descriptive or Intervention)	Major identified health risks and barriers to health services	Potential strategies alleviate health risks	References
Intervention Study	Lack of trained community health liaisons (community health workers) Limited access to existing services through health promotion Limited culturally competent programs Lack of adequate facilitators trained to engage patient navigation through a complex health system	Train and educate community members in leadership and health promotion to increase social capital facilitate access to care Implement and evaluate culturally relevant programs or interventions to increase service utilization and patient navigation	Im and Rosenberg (2015) Mitschke, Aguirre, and Sharma, (2013) Subedi et al.,(2015) Yun et al., (2015)

Descriptive studies. In this review, descriptive studies primarily examined health risks and barriers to services**.** Descriptive studies focused on self-reported health behavior and perceived risk for serious health concerns by examining social norms and risk factors specific to these individuals. Additionally, cultural factors were addressed such as religion, language, and dietary practices to gain a better understanding on influences of health in Bhutanese refugees. The two major types of studies in this category were those which emphasized health behavior and health perceptions, and studies which generated a community health assessment or profile for the target population.

Health behavior and health perceptions. In a mixed methods study, Haworth et al. (2014) administered surveys and focus groups among Bhutanese refugee women to assess health perceptions and behavior practiced for cervical cancer prevention. The

study outcomes showed that health was seen as being primarily individual-based, and there was little to no knowledge of cervical cancer screening or prevention among this community. This study also found low levels of perceived susceptibility to cancer risk. Health promotion programs and communication with providers about prevention was limited. Cultural stigma, shyness, and language barriers were major factors identified as deterrents to obtaining care. These personal attitudes and perspectives on sensitive health topics such as cervical cancer can greatly affect seeking treatment and should be acknowledged prior to health promotional efforts for behavior change among these groups.

In another study, individual level factors such as language barriers were also found to be a significant factor in acculturative stress, noting that English proficiency and educational attainment correlated highly with stress (Benson et al., 2011). While religious beliefs and practices were thought to be important coping mechanisms in alleviating this stress, it was found that religion in the Bhutanese community played more of an important role in maintaining ethnic identity and in the continuation of cultural practices after resettlement (Benson et al., 2011). Strong ethnic ties and retaining tradition can help with the adjustment process and specific behavior can affect individuals in different ways. For example, a different study looking into cultural practices observed food and dietary behavior of Bhutanese refugees found meal preparation and content stayed consistent with practices in the refugees' home country (Kiptinness and Dharaod, 2011). Cultural values and behavior such as language, beliefs, religiosity, and even food are aspects which may be overlooked but can serve a larger

purpose in maintaining tradition and culture in an unfamiliar place (Kiptinness and Dharod, 2011; Benson et al., 2011).

Understanding specific health behavior and health perceptions can impact the ways individuals view their social world, which in turn can also affect perceptions and attitudes about common health issues, such as emotional coping from stress, communication with providers, and nutrition and healthy eating behaviors. The impact of resettlement on health on can be negatively affected from stress of having to live in an unfamiliar setting, especially when language, beliefs, and practices may be vastly different from the home country. Learning about existing knowledge and attitudes can be beneficial in conducting programs in a relevant and culturally appropriate manner, which ultimately can help improve healthy behaviors and reduce health problems in the community.

Generating community health assessments or health profiles. Other descriptive studies in this review sought to generate community health assessments or health profiles for the Bhutanese refugee community. By examining factors relevant to community health, it is possible to understand the major issues or barriers faced by vulnerable groups and areas in which more attention is warranted. Since the Bhutanese refugee community is still a new population, broad views on health can help set the stage for future health research.

Community health assessments are a way to gather various types of health data to initiate steps towards improving and prioritizing health issues. One study (Misra et al., 2015) generated a community health needs assessment using surveys in Houston, Texas,

specifically for the Bhutanese refugees. The findings focused on areas of physical health, such as chronic health conditions and dietary behaviors, and also an included mental health component which examined depression-related symptoms. The findings also showed high rates of blood pressure and chronic conditions, and low levels of physical activity. Another study focusing primary on physical health (Bhatta et al., 2014) further found low physical activity as well as high prevalence of chronic disease and obesity in female Bhutanese refugees. The surveys administered in these two studies sought to better understand sociodemographic influences on important health outcomes studies and found that chronic conditions, obesity, lack of exercise and challenges in health care navigation were found to predominantly affect this group.

Community surveys were also utilized to report on mental health findings. Vonnahme et al., (2015) administered a large scale cross sectional survey to report the prevalence symptoms of depression and other mental illnesses to recommended strategies to mental health improvement in the Bhutanese refugee communities. High rates of depression symptoms were found among women and high mental health comorbidities among Bhutanese refugees were seen. Social isolation and lack of social support correlated with more depression symptoms among this group as well.

Mental health problems are more prevalent in Bhutanese refugees than many other refugee groups (Vonnahme et al., 2015). Suicide is an ongoing concern in the Bhutanese refugee population, and a recent study explored the social aspects to suicide and suicide ideation among Bhutanese refugees by interviewing close family members and contacts to individuals who had committed suicide (Hagaman et al., 2016). These

interviews helped to highlight factors that can be points of intervention to prevent further suicide from occurring in these communities. Studies specifically focusing on mental health can serve to uncover barriers to having a positive mental health status in Bhutanese refugee communities, with an outcome of a detailed mental health profile for the communities observed. Similar to a community health assessment, the mental health assessment can point towards community-level aspects such as social support and local resources to at helping the community better understand and handle mental health problems. Promoting local participation in community health issues is a strategy to build capacity and maintain long-term change for the health status of these groups.

Intervention studies. In this review, intervention studies focused on implementing specific programs or interventions to address health risks**.** Intervention studies used various types of approaches for health improvement in the community, such as training models or innovative program implementation. Through active participation in local health issues, health status can be improved by encouraging community members' interest in their own health. Research has found training individuals in areas such as leadership and skill-building can help lead to a stronger sense of community (Mitschke et al., 2013). The two major types of studies within this category were interventions utilizing community-based training models and interventions which aimed to improve the navigation of the health care system for the target population.

Community-based training models. For Bhutanese refugees, health programs that focusing training individuals to develop leadership abilities or applicable life skills can allow for increased community engagement and social capital (Im and Rosenberg,

2015; Mitschke et al., 2013). Utilizing community-based interventions can increase cultural relevance of programs and build on existing strengths of the community to improve overall health status. Training community members to help one another and become more cognizant of health issues which they may be susceptible to can give group members a greater sense of agency and power in their own health outcomes (Moore & Fletcher, 2012). In this review, two studies implemented interventions at the community level to build community ties and networks and awareness of health issues.

By using a peer-led intervention, Im and Rosenberg (2015) trained community members on leadership and group facilitation so they could conduct sessions on health education for other community members. The community health workshop focused on nutrition and healthy eating, as well as coping skills to reduce psychological distress relating to resettlement and issues facing community. Knowledge of health and awareness of resources, and increased social capital and sense of belonging contributed to a stronger feelings of community connectedness following the study. Conducting health promotional activities with peer leaders helped to increase perceived social support while maintaining cultural relevance to health issues due to the collaborative nature of the community-based model.

Social support has also been shown to increase in areas such as skill-building in group settings among those with common interests. Mitschke, Aguirre, and Sharma (2013) implemented an intervention to understand the impact of a group based financial education course on mental health, finding that higher levels of social cohesion occurred with a structured group setting focusing on applicable skills in financial literacy.

Participants in the intervention group had better mental health in the long-term and all groups experienced increase sense of social support. These interventions aimed to improve health at the community level by facilitating dynamic group interaction in comfortable settings. This can be beneficial to both physical and mental health and can have long-term impact for refugee communities (Im and Rosenberg, 2015; Mitschke, et al., 2013).

Interventions to navigate health care system. The remaining intervention studies in this review focused on barriers towards access and utilization of health services. Upon arrival to the US, refugee groups may be met with a wide array of health services but limited knowledge or ways to gain access to these services. The complex health system in the United States can be intimidating and difficult to understand, which can lead to low access and declining health conditions. Helping community members recognize health problems and make use of existing resources can help these groups better navigate complex health care system. Studies in this category aimed to increase utilization of services and access to care so that system-level resources may be easier to obtain and become more valuable for the Bhutanese refugee community.

After implementing a patient navigator health program where community members are trained to serve as health liaisons (or "health focal points"). Yun et al., (2015) found knowledge of services and help-seeking behavior improved. Problems with access were brought to attention through the program, including issues such as payment for health care, insurance coverage, and lack of relevant life skills. Once health focal points were trained, they assisted community members in learning and accessing health

services in the community. A major outcome from the study included increased patient activation from participants. Patient activation has been referred to as "knowledge, beliefs, and motivations [needed] to become 'activated' or more effectual health care actors" (Hibbard, Stockard, Mahoney, & Tusler, 2004, p. 1006).Training community members to help one another navigate the health care system and increase patient activation can lead to improved confidence and self-sufficiency, which in turn could lead to increased use of health services in the future.

Subedi et al. (2015) also conducted a training program to improve help-seeking behaviors with a focus on mental health. The Mental Health First Aid training program aimed to increase knowledge and awareness of mental health issues and ways to respond to common problems which may be found in the community. A major component of the program involved awareness on strategies to respond to mental health illness through referrals to services available within the mental health care system. After the program, participants reported increased confidence in providing help in a mental health crisis and were more likely to encourage referrals to mental health professionals. Awareness of mental health services available in the community increased, which could potentially lead to an increase in service utilization. This is particularly useful in the Bhutanese refugee community due to their known susceptibility to mental health problems and illness (Subedi et al, 2015).

Discussion

This systematic literature review provides an overview of existing literature of health related studies among Bhutanese refugees in the United States. By analyzing

various study elements and major outcomes, it is possible to identify contributing social and cultural factors influencing health behavior, perceptions, and effective program implementation among these groups. The results of this review suggest that while Bhutanese refugees in the US experience a wide variety of health disparities, one of the major concerns for these groups is mental health problems. Additionally, studies which encompassed a holistic approach by including both physical and mental health yielded pertinent information for improving health among these groups. More programs are needed to be implemented in order to fully address the multifaceted health problems Bhutanese refugees face in the United States.

This review also demonstrated that descriptive studies used various methods to determine health problems and prominent health issues of the community, but few utilized community health assessments which can be a valuable foundational tool for health improvement. Administering a community health assessment as a basis to build health promotion programs has been seen to be effective to increase participation and community involvement in health improvement (Felix et al., 2010). Community health assessments or health reports can help develop a specific agenda for future research in areas shown to be most at risk and facilitate collaboration with local community partners, increase utilization of available resources, and strategize health plans for shared goals to improve identified health needs (Felix et al., 2010).

Understanding the prioritized health needs of a vulnerable community can also direct relevant culturally and linguistically competent research and utilize community based approaches to increase knowledge, social support and recruitment and retention in

research (Hanza et al., 2016). For example, other studies which address health needs of specific refugee groups through a community-based and culturally tailored approach have found unique health needs and characteristics of a group which is particularly valuable in improving health of the population addressed (Lightfoot, Blevins, Lum, & Dube, 2016). It is important for public health programs to incorporate a general understanding of the target community and its particular health needs in order to effectively improve the health of the population studied.

While health profiles can be useful for gaining a deep understanding of health risks and barriers in the community, it is also necessary to translate issues into evidence-based interventions. Existing research with refugee groups and vulnerable groups has shown that interventions which integrate community members with local resources and address social determinants to health needs can be useful for reducing disparities among these populations (Goodkind et al., 2014). The limited number of intervention studies in this review aimed to improve health of Bhutanese refugee groups in the United States indicates the growing need to take advantage of valuable data gathered from health profiles and assessments and implement these into measurable and relevant health programs for the community.

Studies which incorporate a holistic approach by addressing problems at multiple ecological levels, can also help address the complex and multifaceted needs of refugee groups and improve and maintain healthy behaviors. This review revealed only two studies at multiple ecological levels, which were at the community and individual level. While programs at each level has their own strengths, an important component of the

social ecological model in health promotion is interconnectedness and reciprocity of interaction at each level. In other words, implementing change at one level can have significant impact on other ecological levels of health (Stokols, 1996). Thus, implementing a program accordingly with consideration at multiple levels would be especially effective (Mcleroy et al., 1988; Stokols, 1996).

Moreover, the lack of focus on system level barriers as seen in this study can limit the abilities of vulnerable groups to access available health care and gain knowledge to understand the US health system. More studies are needed which include a component to reduce system-level barriers can enable individuals and communities to better understand and navigate health care institutions and available resources. The potential outcomes and benefits of the system level are increased knowledge and awareness of health services, as well as increased patient activation skills (Scott, Gravely, Sexton, Brzostek, & Brown, 2013). For example, training community leaders to promote existing resources can help communicate knowledge in through relatable and relevant channels to overcome barriers to utilization of health care services at this level (Markham, Islam, & Faull, 2014). Additionally, supporting change from within the system, such as long-term follow up to health issues beyond initial resettlement assistance from government programs, can assist communities in understanding their rights and resources available from their health care system.

This review has demonstrated that much can be learned from synthesizing data from a refugee group which can help health researchers gain a deeper understanding of the particular needs and cultural considerations vulnerable groups. Specific cultural

values and beliefs can play an important role in shaping the health behaviors of the refugees. These health behaviors can also serve a larger purpose in helping to retaining reaffirm ties with home countries and aid in teaching coping mechanisms relevant to the social norms and values of refugees. Understanding the meaning attributed to different types of health behavior based on the knowledge, attitudes, beliefs and practices of particular refugees is important to take into account to have a significant impact in the health of these groups.

Data collected in this review gave insight to specific gaps in knowledge and intervention strategies to for health research in Bhutanese refugees, such as the role of religious attachment, low rates of preventive screening, importance of language barriers and environmental stressors of newly resettled refugees. These factors can vary by group but are important topics to consider when conducting research or implementing programs, as every group may have unique characteristics or capabilities which can impact health research and program effectiveness.

Limitations

The limitations of this systematic literature review were the small number of studies on Bhutanese refugees conducted in the United States. Many studies were excluded due to the inclusion of various other refugee groups, which made isolating Bhutanese refugee characteristics difficult. Limited studies on Bhutanese refugee health are also due to Bhutanese refugees are among the newest refugee groups arriving to the US, so years which programs were conducted were not available prior to 2006-2007. Since several of the studies were community health assessments conducted fairly

recently, it is possible there has not been enough time for these reports to be integrated into programs or interventions. However, these reports were located in areas which have some of the larger populations of Bhutanese refugees, and programs based on this data could still have a significant impact on these groups in the future. Other studies included in this review also generated an informational assessment of health concerns and did not implement actual programs or intervention to date. The large amount of data demonstrating health disparities among Bhutanese groups, coupled with the small number of completed interventions programs targeted at improving health of Bhutanese refugees demonstrates the urgent need for program adaptation and implementation among this population. Nevertheless, this review can still be utilized as a general guideline for refugee community health needs and important barriers to consider when designing programs for resettled refugee groups.

CHAPTER III

A QUALITATIVE ASSESSMENT OF HEALTH EXPERIENCES OF A BHUTANESE REFUGEE COMMUNITY IN WORCESTER, MASSACHUSETTS

Introduction

Refugees in the United States face multiple challenges and stressors in health and access to health services. Many are resettled after living in poor conditions in refugee camps burdened with untreated chronic health conditions and diseases (Morris et al., 2009). Prior to their arrival to the US, refugees face physical, emotional, and mental hardship due to political violence, ethnic conflict, or other trauma in their home country or in refugee camps (Vergara, Miller, Martin, & Cookson, 2003; Yun et al., 2015). In addition, refugee camps generally have low access to health services and lack adequate health care services (Vergara, et al., 2003). As a result, refugees may be unaware or unwilling to seek treatment for physical or mental health post-resettlement (Miller, 2004). Over time, this can cause an underutilization of health services and exacerbate chronic and complex health problems and contribute to health disparities among refugee groups in the United States.

These disparities occur due to factors such as a lack of formal education, little English-speaking ability, and an overall lack of preventive care or health promotional efforts in their previous residence (Goodkind, et al., 2014; Navulvuri et al., 2014; Lamkaddem et al., 2015). To help reduce social and structural inequalities in health of vulnerable groups, it is important to first assess perceived causes of health problems in

order to design intervention programs to improve health outcomes of the community (Whitehead, 2007). Gaining detailed information from speaking directly with community members, leaders, and professionals can add valuable insight to the problems facing the population, as well as strategies to overcome identified barriers (Whitehead, 2007; Minkler et al., 2003). Focused discussion groups and in-person interviews can help give a voice to disadvantaged groups who can be overlooked due to limited ability to speak English, experience cultural barriers, or lack of connections within the new unfamiliar environment (Esposito, 2001; Woodgate et al., 2017). Previous studies which emphasized qualitative methods to explore and understand the experiences, perspectives, and health needs of refugee groups, such as Somali refugees, have found unique cultural attributes which may have been otherwise difficult to discern through other means of data collection (Carroll et al., 2007; Betancourt et al., 2015; Lightfoot et al., 2016). These studies have found the importance of community ties in health promotion and the significance of a shared traumatic history as refugees as contextually significant when building rapport, participation, and involvement in local health improvement strategies.

Among the thousands of refugee groups coming to the US in the past decade, the Bhutanese are among the largest resettled population, and are also a commonly overlooked group (Mitschke et al., 2013). Bhutanese refugees have an ongoing history of instability and trauma, throughout political conflict in Bhutan and subsequent suffering in refugee camps in Nepal. In the refugee camps, this group survived two decades of overt discrimination, unacceptable living conditions, and inadequate health care services. In the late 2000's the United Nations took notice of the situation and

began resettling the Bhutanese refugees into developed nations around the world. Since 2007, over 100,000 Bhutanese refugees have been resettled in seven different countries, making this group the largest refugee resettlement program (Office of the United Nations High Commissioner for Refugees [UNCHR], 2015).

Previous research examining general community health needs of Bhutanese refugees have largely administered cross-sectional surveys or demographic questionnaires to gain information among various Bhutanese communities (Benson et al., 2012; Bhatta et al., 2014; Hagaman et al., 2016). Among the qualitative or mixed methods descriptive studies, the focus has been on a specific health issues and related factors (Kiptiness and Dharod, 2011; Haworth et al., 2014). Additionally, there is a limited amount of research on the Bhutanese refugees in Northeast United States, though there were almost 2,000 resettled in Massachusetts between 2008-2012, with several hundred currently living in Worcester, a city in central Massachusetts and home to some of the largest groups of refugees in the state (Fabos et al., 2015). There is limited data on Bhutanese refugees health needs in Worcester, though they accounted for over one-fourth of the total number of refugees between the years of 2008-2012.

The purpose of this study was to conduct an in-depth qualitative study to examine Bhutanese refugee health experiences in Worcester, Massachusetts in order to understand the factors at individual and community levels. Qualitative research, particularly with vulnerable populations, provides an in-depth examination of thoughts, feelings, and explanations of experiences which may otherwise be difficult to obtain. A valuable outcome of qualitative methodology in health is that it can provide a foundation

for reducing health disparities among disadvantaged groups (Sullivan-Bolyai, Bova, & Harper, 2005).

Specifically, a phenomenological approach was used for the framework and analysis of this qualitative study. This approach is commonly used in qualitative methods for health sciences in order to examine meanings ascribed to subjective lived experiences of certain phenomena (Davidsen, 2013; Penner & McClement, 2008). Meanings are uncovered through shared characteristics, experiences, and historical contexts of individuals which can give a holistic view of the scope of the problem (Benner, 1994; Davidsen, 2013). These meanings, gathered through different avenues of data collection and interpretative analyses, can be thematically organized and reported to explain how individuals understand specific aspects to their everyday world, such as experiences with health and obtaining health care. In health promotion and community health, this can serve as a platform for advocacy and social justice to represent underserved groups and make steps towards health improvement in these groups (Carlisle, 2000).

By utilizing data from forty-six participants through focus groups and key informant interviews, as well as including participant observation though time spent with the community, this study aimed to describe and thematically analyze the major health problems from the perspective of the community. The patterns in the data are categorized and reported based on a modified social-ecological model (McLeroy et al., 1988) which include individual, community, and system levels. At the individual level, health programs target individual behavior change through education and training by

addressing personal characteristics such as knowledge, attitudes, and beliefs about health. The community level targets the social and cultural environment and ways to improve health through capacity building and advancing relationships among local groups, organizations and institutions (Golden & Earp, 2012). A major focus at this level is building social support and improving community health by utilize existing community strengths and resources. At the system level, programs aim to addresses policy-level issues such as creating or altering public laws and regulations and other activities to improve health across social or political systems (Golden & Earp, 2012).

The outcomes of this study can provide information and a foundation for designing culturally appropriate and relevant social and behavioral programs to increase health access and utilization among Bhutanese refugee groups. Additionally, this study can serve as a guide for health professionals in strategies for gaining a deeper understanding of disparities faced by refugees through inputs from community-based group discussion. The following research question was used to guide this study: What are the major health problems and barriers to health care within the Bhutanese refugee community of Worcester, Massachusetts as perceived by local community members and leaders?

Methods

Study Site

All of the data collection occurred in Worcester, a city in central Massachusetts with an estimated population of almost 185,000 (US Census QuickFacts, 2015). Worcester has one of the largest numbers of resettled refugees in the state, and

Bhutanese refugees began arriving during the initial resettlement process around 2008 (Fabos et al., 2015). Various organizations exist to assist refugees particularly in the local area, such as the Worcester Refugee Assistance Project, the Refugee and Immigrant Assistance Center and Ascentria Care Alliance, formerly Lutheran Social Service. The Bhutanese refugees emphasized the important role the Lutheran Social Service agency played in their transition to the United States, which was where they gained much of the information needed currently and during their initial resettlement. As the Bhutanese refugee community grew, they were able to establish more resources, such as religious institutions, markets, and community-wide social support to sponsor events and cultural gatherings. Their close ties allowed three of the four focus groups to be held in the home of one of the participants per group, who volunteered to use their space for the study. One focus group was held at the local community Hindu temple. Each location was carefully considered to ensure convenient access for community members, and carpools and rides were provided by community contacts and the researcher for those who needed extra help attending the group.

Ethical Approval

This study was approved by the Institutional Review Board (IRB) through the Division of Research at Texas A&M University.

Data Collection Procedure

Recruitment. Participants were recruited through word-of-mouth and snowball sampling among community contacts and gatekeepers in the local area of Worcester, Massachusetts in the months of May and June 2016. With the researcher as bilingual and

having prior knowledge of the culture and language of the Bhutanese refugees, as well as visits to Worcester and engaging in conversations with community leaders, families, and community members, it was possible to develop trust rapport among this group. After establishing contacts among several community leaders and knowledgeable persons in the local area, these individuals were well-connected in the community and served as voluntary liaisons, and assisted gaining valuable access to willing community members and study information dissemination for participant recruitment. Through phone calls and in-person visits, as well as referrals by key informants, focus group participants were organized and more interviewees were contacted through snowball sampling with the initial community leaders. Focus groups and interviews occurred between June and November 2016, which was when data saturation was reached in which data did not provide additional or new insights and perspectives (Ulin et al., 2005).

Focus groups. Participants in the focus group study were adult females (age 18 years and older), who were Bhutanese refugees of Nepali ethnicity and currently resided in Worcester, Massachusetts. Forty total participants were included in the focus group portion of this study. Participants were asked to give verbal informed consent for audio-recording. Information regarding details of the study was also distributed. No participants refused to take part of the study. They were also informed that they could leave at any moment of the study or decline to answer any questions, including those on the demographic questionnaire. Each focus group lasted between 1-2 hours with 8-12 participants each and all were conducted in Nepali.

Focus groups were all audio-recorded for the duration of the meeting, and the researcher served as the group facilitator, as she is bilingual in the native language of the refugees. A semi-structured interview guide was developed, with questions and topics of discussion created after collaboration with local community contacts to ensure materials' cultural relevancy and applicability to the community. At the start of the focus group, a bilingual community liaison would assist in appropriate translation of the introduction of the study topic and purpose if needed, and was also consulted before the focus groups to review questions, procedure, and any other information on specific considerations as necessary.

At the completion of the focus group discussion, participants were given a demographic questionnaire to gather general information which was available in both English and Nepali. In this questionnaire they were asked to not include their real names or any specific identifiable information. For those who were illiterate, a community liaison or a bilingual member of the focus group assisted in completing the questionnaire. Among the 40 questionnaires provided, 36 were submitted with most answers complete. Table 3 displays averages of demographic information obtained by focus group. Overall, the youngest member of the focus groups was 24, and the oldest was 65. Most participants lived at least 15 years in the refugee camps, and had lived in the US for a minimum of close to 1 year. The majority of participants did not have more than 8 years of formal education, and also felt they knew little to no English. Additionally, self-reporting "fair" health was the most common response across the focus groups.

Interviews. The participants for the key informant interviews were adult (age 18 years and older) Nepali-speaking Bhutanese refugees and given informed consent at the beginning of the study for audio-recorded sessions. Both females and males were included in the interviews, with half of the six total participants being female, ranging in age from early 20's to late 40's. The key informants were known community leaders with connections to the local health care system or participation in social activism for the Bhutanese refugee community. Interviews were conducted based on a semi-structured interview guide and lasted forty minutes to one hour each, with all interviews being conducted at the home of the participant at their request. The interviews were also conducted in the language of choice of the participant, in which all but one were in English.

Participant observation. In addition to semi-structured interviews and focus groups with community members, an element of ethnographic research was also conducted which included participation observation through time spent with the community and documented reflections of the immediate environment. The general area of Worcester, and particular where the majority of the Bhutanese refugees reside, was similar to other cities in central Massachusetts, with multi-family homes in hilly neighborhoods and a constant flow of cars, buses, and people. The immediate built environment varied, with numerous neighborhoods lacking sidewalks and few streetlamps, though parks and recreational space was also a short drive away. Different streets were comprised of communities of different ethnicities and races and there appeared to be limited cross-cultural interaction.

The distinct ethnic communities also became apparent after seeing the shops, alongside commercial stores, based on different countries and cultures. After speaking with workers in the specific shops catering to Nepali residents, it was evident there was a large enough Bhutanese refugee population that they were able to establish their own markets and imported goods run by both Nepalese and Bhutanese origin community members. They also noted that these shops were relatively new, as those who arrived to Worcester shared accounts of experiences difficulty early on as they primarily relied on local supermarkets, Indian grocery stores, or other means to purchase the food and supplies needed.

The Bhutanese refugees as a population remained concentrated in specific areas of Worcester, and could be seen conversing and continuously participating in various events, such as weddings and funerals, together as a community in designated areas. Families often lived in homes consisted of multiple generations as this is common practice in Nepal and Bhutan. For example, many Bhutanese refugee adults would gain employment and financially support their family, which often included their elderly parents and children. Some were the official caregivers of their parents and received government support and assistance for their responsibilities, while others would provide for the family while their parents would care for their grandchildren, which also was shown to help maintain the culture by teaching the language and traditions of their home country. The families were close to one another and referred to each other through familial relations (such as calling each other uncle, aunt, brother, sister, etc.), even if they were not related.

There is a local community organization of Bhutanese refugees in Worcester in which members gather for cultural and religious holidays and happenings, and occasionally participate in events with other Bhutanese refugee organizations in Massachusetts, New England, and various parts of the United States. Contact with others and news about events were established through social media, mutual friends, or other forms of communication. The social media page via Facebook currently serves as a platform for Bhutanese refugees of Worcester and Massachusetts to learn about activities, job opportunities, or other information for local resources, though it appears to be tailored towards those proficient in English and basic technological skills..

Many community members, particularly the older adults and newly arrived, dressed in their traditional clothing. Individuals participated in Hindu religious practices and their apartments were decorated with traditional cultural artifacts from Nepal. Though seemingly initially hesitant about what to expect when participation in research, the focus group volunteer who offered to use their personal homes to conduct the group would always offer tea and snacks, as customary practice for all guests, and this ended up helping put others at ease, especially since many were unfamiliar with one another. The shared customs, language, and community were important in establishing trust, comfort, and willingness to engage in conversation and discuss various issues.

Data Analysis

Focus groups and interviews were transcribed verbatim in the language conducted by the researcher who is fluent in both Nepali and English. For the protection of the participants, only pseudonyms were used for all transcripts and final reports. All

Nepali transcripts were translated into English. To maintain consistency as well as to ensure original meanings of the participants, audio transcripts were also back-translated and reviewed by a bilingual certified medical interpreter.

Focus group and interview transcripts were analyzed using ATLAS.ti, a qualitative software program. Data from focus groups, interviews, memos, and notes from participant observation were coded and re-coded, and categorized to consolidate data and meanings based on shared patterns (Saldaña, 2015). These codes were conceptually categorized and constantly compared and analyzed. A coding schema was developed through an inductive coding process including reoccurring codes which had been collapsed into broader categories. Notes and memos were included throughout the coding process to document commentary. Thematic concepts emerged during the coding process which were organized based on commonalities of codes (Saldaña, 2015). Final themes generated were then defined and presented as the results of the study with supporting quotations and observations (Saldaña, 2015).

Results

Participant Characteristics

The following table (Table 3) illustrates the averages of participant characteristics in the focus groups as indicated through self-administered demographic questionnaires given at the conclusion of focus groups. Among the 40 focus group participants, 35 turned in the questionnaire with the majority of questions completed.

Table 3.
Focus Group Participant Characteristics (Averages) Based on Demographic Information Obtained Through Questionnaire

Focus Group	**Total Participants**	**Average Age**	**Years in refugee camp**	**Time in US/ Worcester**	**Years of formal education**	**Self-reported English proficiency**	**Self-reported health status**
1	10	47	21 years	3 years	3 years	Fluent (1); Some (1); Little (2); None (4)	Excellent (1); Very Good (0); Good (2); Fair (4); Poor (2)
2	10	53	17 years	4 years	1 year	Fluent (1); Some (2); Little (2); None (3)	Excellent (0); Very Good (0); Good (2); Fair (5); Poor (1)
3	12	45	18 years	5 years	2 years	Fluent (0); Some (4); Little (3); None (5)	Excellent (3); Very Good (2); Good (1); Fair (4); Poor (2)
4	8	50	18 years	5 years	3 years	Fluent (1); Some (1); Little (2); None (2)	Excellent (0); Very Good (0); Good (2); Fair (4); Poor (0)

In the first focus group, out of 10 participants, 9 completed the questionnaire. The average age was 47, with the youngest being 24 and oldest 64. Participants spent an average of 21 years in the refugee camps, and lived in the US between 1 and 6 years. Most did not have more than 2 years of formal education, with the exception of two participants who had high school degrees. Most participants reported no English proficiency and “fair” health status.

In the second group, of the 10 participants, 8 completed the questionnaire. The average age was 52, with the youngest being 37 and oldest as 65. Participants spent an

average of 17 years in the refugee camps and 4 years in the US. The majority of participants had no formal education, with the exception of two who had around 8 years of schooling. Most responded they had little to no English proficiency and "fair" health.

In the third focus group, all 12 of the participants submitted the questionnaire. The average age was 53, with the youngest as 29 and the oldest reported as 52. The average time spent in the camps was 18 years, and time in the US was 5 years. Participants had an average of 2 years of schooling. None of the participants reported fluency in English. Though more reported "excellent" health than any other group, most participants still rated their health as "fair."

In the fourth focus group, out of 8 participants, 6 submitted the questionnaire. The average age was 49, with the youngest being 34 and oldest being 65. Participants spent 18 years on average in the refugee camp and 5 years in the US. The majority of the participants had no formal education, with the exception of two which completed 12 years and 15 years of school. The English proficiency varied with half the respondents reporting high levels. Most also reported their health as "fair." In the focus groups, the themes which emerged during data analysis and described in the next section included 1) participants discussions on their experiences influencing their health behavior, 2) the social and institutional barriers to positive health in their community, and 3) cultural conceptualizations of health.

System Level: Influence of Past Health Care Experiences on Present Health

When asked about currently health behaviors, participants consistently shared stories of their health experiences in Nepal and the perceived persistent discrimination. It

became apparent the past experiences largely influenced their perspectives and views on present health behaviors, particularly within the institutional health care system. While initially living in the refugee camps in Nepal, the Bhutanese refugees were heavily discriminated against in the health care system, and their health was often neglected and overlooked. The poor quality of care and mistreatment by those in the health care system led individuals to negatively view health access and treatment. It is possible that inadequate health care can also be due to the overall lack of proper infrastructure, resources, medical equipment and trained personnel, which is common in developing nations. However, in this particular group, embedded in the stories of poor quality of care received were also feelings of discrimination, oppression, and neglect they felt based on their background and status as Bhutanese refugees. When health became associated with persistent discrimination, over time, treatment for health issues was only sought on an as-needed basis. This inevitably influenced present behaviors, as seen throughout the study through limited accounts of known health promotion programs or preventive practices in the community. The following quotations reflect the discussions of negative past experiences in Nepal with health. This became the foundational aspect of their conceptualizations of health in the community.

Historical discriminatory health practices. The Bhutanese refugees encountered various forms of institutional discrimination during their time in the camps in Nepal. In the healthcare system, Bhutanese refugees faced many inequalities as participants recounted numerous instances of mistreatment in health clinics in Nepal. This led to health and seeking health care as symbolic of persistent discrimination. For

example, they described feeling constantly neglected and placed in a separate line than the local Nepalese (citizens of Nepal) for treatment. The line with the local Nepalese was prioritized, and the Bhutanese refugees were the last to see medical staff for treatment. Participants noted these actions had harmful or even fatal consequences.

> Right when we said we are refugees, people would treat us differently. They would discriminate. The doctors would hesitate to treat us, they would think that, 'ok, these people are refugees, they need to wait.' Every time. […]They would take our name, put in a separate line for refugees so then they treat us last, and by the time the sick person's name was called they might have died already. Many died like that. (Sajita, age 40, 3 years in US)

> They [the local Nepalese] would call up their own people first to get care, you could not even argue. The doctors would say you are making a fuss if you argue to them, and slam the door in your face. And we were there to save our kids right? So we had to be quiet. (Anju, age 44, 8 years in US)

Sajita and Anju's description of the atmosphere of the health clinics in Nepal represented the experiences of most of the participants. Once their refugee status was known, the doctors would be reluctant to give treatment and refugees had to risk being turned away for serious conditions. Eventually, the refugees would only seek treatment when their condition was serious enough that they felt they may not survive, and even then, treatment was not guaranteed. Those who were fortunate enough to obtain treatment then might have faced doctors who were unwilling to closely examine their cases.

Anju further described her personal confrontation with a doctor in Nepal when she was finally able to see one:

> When [my child] was referred to a hospital outside the camp, the doctor there said, 'Why did you bring this little girl? She's fine, she's still breathing.' I said, 'If she was not breathing I would have buried her already, why would I bring her here, to you? It's because she is breathing that I am bringing her to you, so that you can find out what is wrong and give her treatment. If you can give her treatment, do it, if not then tell me what needs to be done' I said. (Anju, age 44, 8 years in US)

In this story, Anju's daughter had been unable to cope with asthmatic symptoms and had been suffering for many nights. The clinics in the camps did not have the medicine or capacity to handle her situation, so they referred her to a hospital near the camp, which was common practice for serious conditions and illnesses. Other participants agreed that they had to fight to be seen or heard by doctors, and still many would be turned away. Even when treated, many women had stories of abuse by the hospital staff.

The constant mistreatment of Bhutanese refugees in the health care system affected their quality of health and longevity. Since many of the refugees lived in the camps for almost two decades, they also became more at risk for increased suffering from chronic illness, disease, and serious health conditions. Several participants believed that if they had remained in the camps in Nepal, they would have suffered greatly or even lost their lives. Two responds agreed with Mila's observation: *"I have many sicknesses…if I was still in Nepal, I would have died already"* (Mila, age 56, 6 years in

US). Others also commented, "*[Doctors in the US] saw right away I had a gallbladder problem and needed an operation…if I was in Nepal I would have never gotten better.*" (Ritika, age 47, 7 years in US). In a different focus group, one participant shared story of her struggles with health while in Nepal.

> If I was in Nepal, I would not even be able to walk right now after getting sick. I would probably be crippled. I could not speak well. They [doctors in the US] said it was a stroke…They had me do therapy and rehab. But if I was there, if I was in Nepal, I probably would not have made it. (Anu, age 56, 6 years in US)

These participants, among others, expressed the importance of timely treatment and the risk posed to their health and lives had they stayed in Nepal. When living in Nepal, many would not receive adequate treatment for what would often be preventable illness. In the following quote, Jay illustrates his experience with his father and the consequences of poor treatment in Nepal:

> Most of the people, they are suffering from the, the old sickness they had in the camp because we didn't get proper treatment…in my dad's situation, he had COPD [chronic obstructive pulmonary disease] for many years, and didn't get proper treatment…So when he came here, he had the COPD, and it was the last stage. It was too late. So he passed away two years ago. (Jay, late 40's, nonprofit worker)

Like Jay, adults who were sick or had sick relatives felt that if they had received better treatment, or information on how to deal with certain illnesses on their onset, they would have lived longer and suffered less. In Jay's case, he realized later that COPD is a

preventable disease and that proper treatment may have saved his father's life. While there were significant issues with the hospital infrastructure and available resources, when participants referred to health care in Nepal, this often was followed by stories of discrimination and problems specific to feeling that the system and staff treated them unfairly based on their refugee status. The discriminatory practice led to overlooking health concerns, mistreatment, and sometimes exacerbating the health problem due to neglect. Due to these issues, participants said that eventually in the refugee camps, they avoided seeking care in unless they felt there was no other option, and their health suffered greatly.

When delving deeper in the interviews to find current health practices and behaviors, it became apparent that members of the community still regarded health care as a resource for emergency services or urgent treatment; there was still a lack of predominant prevention and health promotion efforts in the community. It is possible that the societal norm of seeking treatment only when there was no other option continued into the Bhutanese refugee community in the US, where there are also very few health promotion programs specifically targeted towards their group. The health information that they were exposed to only happened after visiting a hospital or clinic, and so both treatment and health education occurred at the hospital, urgent clinic, or emergency room. Even when obtaining health information from their doctors or nurses, participants felt they were not able to communicate well with the hospital staff. Most participants expressed frustration in having to rely on the medical interpreters for all of

their health information needs, and emphasized the language barrier among Nepalese interpreters as one of their biggest concerns with health care in the US.

System Level: Current Institutional Barriers to Health

While the Nepalese interpreters provided by clinics and hospitals did speak Nepali, the native language of the Bhutanese refugees, their vocabulary and dialect was different enough that the medical interpretation was a problem. Culture needs to be taken into consideration in health care practice, or it can lead to a patient receiving incorrect information, feeling confusion, or even mistrust towards medical staff (Antshel, 2002). The numerous examples of misinterpretation based on the linguistic cultural inconsideration of Nepalese medical interpreters towards the Bhutanese refugees contributed to a sense of disconnect at the system level in health care institutions in the US. Many refugees felt they were not accurately being represented, or that their communication with the doctors were not being adequately conveyed. This created a feeling of messages being lost in translation.

Linguistic and cultural barriers with interpreters in medical institutions. Though the care in the US was a dramatic improvement than health care in Nepal, when asked about barriers to care in the US, one of the issues brought up most frequently was problems with medical interpreters at the hospitals and health centers. At the local hospitals around Worcester, a medical interpreter is required and provided to those with limited or no English speaking ability. As most of the participants indicated they spoke little to no English, they had various examples of interactions with interpreters, though mostly negative. The interpreters provided for the Bhutanese refugees in these examples

were always Nepalese from Nepal. The problem was that while the language of the Nepalese (Nepali) matched that of the Bhutanese refugees, the cultural aspect of their spoken language, including the dialect and word usage, was different enough so that the Bhutanese refugees felt they were not clearly understood or adequately represented. This was seen as both an interpersonal and institutional barrier for language and communication of in health care among Bhutanese refugees in Worcester. The Bhutanese refugees described the cultural and linguistic competency of the interpreters as insufficient in many cases, illustrated in the quotations below.

> Well, we are people coming from Bhutan, right? Our Nepali and [the Nepalese from Nepal] are not exactly the same. It is difficult to understand. We do not know the different types of dialects…there are many words that we even do not understand, for those of us who are Bhutanese-Nepali. There are words and accents and pronunciations that are different. And so when the interpreter, even when speaking Nepali, it is different than *our* Nepali. (Saru, age 48, 8 years in US)

> My grandmother's biggest complaint when she used a translator at the hospital, um, was that she couldn't understand the dialect… there were certain words that we don't use, you know? My grandparents, they haven't gotten, they couldn't even write their names in Nepali, so it's like, you're talking to them in very formal Nepali, and they just couldn't understand the whole idea. (Riya, early 20s, student)

Throughout this study, participants agreed that they had problems with interpreters because of their cultural background and spoken language. They face the additional burden of not understanding both the English that is spoken by the doctor, as well as the Nepali spoken by the interpreter, which resulted in much confusion and frustration. Many of the participants pointed out the difficulty in understanding Nepali, especially medical terms, during their interactions with the interpreter. They also noted how the interpreters sometimes use English words, so that they are unsure if the right message is getting through and have no way of knowing. Many Bhutanese refugee patients are accompanied by a bilingual family member, even if there is an interpreter provided, because they feel their family can protect them against the potential pitfalls of relying solely on the interpreter. In the example below, Chameli describes a situation which could have been quite harmful to her father because of misinterpretation by an interpreter:

> My husband took [his father] to the emergency room at the hospital, and wanted to interpret for him…[but] they connected him to an interpreter on the phone right? The doctor asked my father if he had any *pain* and where it was. And you know what the interpreter understood? He heard '*pen*' and asked my father, 'Do you have a *pen*, are you carrying a *pen* right now?' [surprise gasps, some laughs from focus group] […] My father might have answered the questions as 'no I do not' to say that he does not have a pen with him, right? Then can you imagine what would have happened? (Chameli, age 34, 6 years in US)

In this example, the focus group members were surprised and sympathetic, as they then began giving their own examples of times when they narrowly avoided unnecessary medical procedures or when they felt their concerns were overlooked because of a problem with interpretation. Some felt this may happen due to integrating English words into the translation for those who do not speak English, or even neglecting attention to detail on the part of the Nepalese interpreter after realizing they are speaking with Bhutanese refugee.

For those who may not have family to accompany them, problems with interpretation for medical problems could have potentially dangerous outcomes. For example, this can lead to misdiagnoses or incorrect information getting through to the patient, since the doctor is already pressed for time and the patient may feel uncomfortable asking for clarification. Some respondents emphasized the cultural characteristics of Bhutanese refugees which are generally not taken into consideration during these visits. Riya detailed the reasons this could be detrimental to health in the community using an example of her grandmother:

> Bhutanese-Nepali people can be shy in general with outsiders…my grandmother, when she got a translator, whether or not she understood the translator, she would just smile and nod the whole time. Because she was very *very* shy. I see that happen a lot. [The refugees are] with a doctor that doesn't even speak their language, and you have this translator that doesn't speak in the same way as you do, so there's a lot of barriers to it. (Riya, early 20s, student)

In this case, Riya would try to go with her grandmother to her medical visits so that she could assist with interpretation as needed, but she was not always available due to school, work, or other obligations. She describes the discomfort they may feel at drawing attention to their inability to understand the conversation or reluctance to appear rude or unappreciative of the doctor's efforts. Other the Bhutanese refugees also spoke of feeling unwelcome by the actual interpreter, who in most cases were Nepalese, not Bhutanese refugees. The shared cultural history and pattern of discrimination towards Bhutanese refugee groups in Nepal has, in some ways, carried over to the US, as expressed by Arjun:

> You know, the Nepalis from Nepal? They do not really like us much. If we tell them that we are Bhutanese… Sometimes they don't always act as decent people. For a lot of them, their attitudes are different than ours, right? Very different. (Arjun, early 20s, student)

In this quote Arjun illustrates the way he feels unaccepted by the Nepalese community because of his background. He observes a different attitude and demeanor towards members in his community. Since many Bhutanese refugees continue to rely on the Nepalese for their health concerns through interpretation, this sentiment was echoed among those in the focus groups who gave examples of interpreters who they felt would sometimes treat them impatiently and carelessly, even in urgent medical situations.

> From [the interpreter's and doctor's] view, they try to do things based on the time they have. But you need to give [our elders] time, you have to slowly understand what they are saying. The Nepalese interpreter, sometimes they will get

> impatient, and the interpreter will say, 'they are not asking you all of that, just answer the question' but for our parents it is hard to do that, they like to talk more. (Ranju, age 50, 8 years in US)

> So many of the Nepali interpreters, they seem to get annoyed, right? They will almost yell at them, saying 'no do not say it like that, say it like this!' there's so many of the interpreters, even to me, saying that. (Radha, 40, 7 years in US)

These examples illustrate ways participants described the cultural norm of their elders or others in their community telling stories or speaking at length about their problems when asked. However, they noticed the interpreters' impatience and occasional rudeness in these situations. Though the interpreter is meant to only translate between doctor and patient, they sometimes overstep the boundaries and break protocol by not letting the patient express what they are feeling. By interjecting their own directions or opinions, they risk putting the patient's health at risk, and may drastically affect the outcomes of their lives.

> For me at the beginning, I didn't know much for the first few months. When I went to the hospital I did get an interpreter right? He was from Nepal, a man, and I told him I have been pregnant for a while…and I asked him if he could ask the doctor something about what I can do [for an abortion]. He [the interpreter] said that 'you should not be talking about that because you will be in trouble', and 'we should not talk about it'. So I did not. (Anjali, age 39, 7 years in US)

In this narrative, Anjali had told the interpreter about her unplanned pregnancy and wanted to ask the doctor what her options were as she was considering terminating the pregnancy after learning of it. The interpreter in this case told her his opinion about her situation and ultimately did not interpret what she wanted to ask the doctor. Since she was new to the country, she did not know what do to and began to fear the consequences of approaching the subject with the doctor since the interpreter told her should will be in trouble. Eventually, after spending time in the US and understanding the culture and language more, she felt confident to bring up her concerns with another doctor. She pointed out, however, by that time she felt it was too late to have an abortion, an option she was considering previously.

This occurrence was a key example of how biased interpretation could change the shape of a family structure and life events. The emphasis on the mistreatment of interpreters from Nepal also led others in the focus group to discuss feelings of being ostracized and rejected by the Nepalese in the US. Even with the arrival of more Bhutanese refugees and increase in medical interpretation certification programs, there is still a very small number of Nepali-speaking Bhutanese medical interpreters. Those spoken to during the study who assisted with medical interpretation did so on a part-time or volunteer basis, and felt they were unable to devote as much time as they wanted to this position. Ultimately, the Bhutanese refugees were most comfortable with their own community members as interpreters in medical situations, which is why they routinely brought family members or close friends to assist with their doctor's visits. They described their frustration with an overreliance on the Nepalese interpreters, who many

felt did not fully understand their culture or their language, or even view them as equals. This demonstrated a lack of cultural and linguistic competence in an important aspect of the healthcare institutions, which proves to be a significant barrier to positive health outcomes in the community.

Community Level: Social and Cultural Barriers to Health

Though they shared a similar language, religion, and various social traits, many of the Bhutanese refugees felt a form of cultural rejection from the Nepalese, as exemplified through the conversations about medical interpreters. This social isolation was further exacerbated by the cultural shock of coming from an open, communal society to the more individualistic and relatively private culture of the United States. At the community level, participants described feelings of social isolation and difficulty with integration into US society. The lack of outside social connections and problems with cultural adjustment can heavily contribute to mental health issues such as depression and anxiety.

Distancing through social and cultural isolation. The feeling of isolation in this community stemmed from language and cultural barriers, as many of the participants had few, if any, years of schooling and were unable to speak English. Though they wanted to communicate with or meet their neighbors, they noted the difference in cultural practice in communities, wherein American society doors remain closed and people have a tendency to keep to themselves.

> When I first came here, we thought there were no others like us, right? There was no way of knowing who people were. People here just go inside and close the

> door, and you have no idea who is back there. […] People can get depressed just keeping these [feelings, thoughts] inside and not sharing. Who else can we talk to though? We can't understand people outside. And if you try to see your neighbor here, the doors stay closed. (Saru, age 48, 8 years in US)

This example represents how others also described the neighborhoods in the US as "closed doors" both in a physical and symbolic sense. One interviewee described the concept of knocking on a door before entering as very surprising, as they were used to welcoming and being welcomed by guests and others in the community in a much more open manner. Seeing the doors closed, and transitioning away from an open sense of community was especially difficult for those who arrived before their communities were established, as they felt the largest impact of this type of culture shock. The closed doors symbolized feeling shut out of society and contributing factors for depression as it forced individuals to deal with their experiences alone.

> For me sometimes it feels as if I am choking. I feel just like that. And why? I do not have education, I cannot read and write, I do not know how to speak [English]... I see people walking around but I cannot say hi or I do not know what to say. I want to talk to them, I want say hi. But they don't understand what I say and I do not understand what they say. And so I am walking around like a dumb person not knowing what is happening. (Nina, age 48, 5 years in US)

In this example Nina describes feeling stifled by the inability to communicate, her lack of education and low English proficiency as a powerful barrier to feeling a part of American society. Immediately after this example she discusses her feelings of leaving

Bhutan and settling in Nepal, drawing an indirect comparison of her resettlement in the US. Other participants described leaving their homes and having to adjust to a new, foreign area multiple times brings feelings of loneliness, discontent and self-doubt. As one respondent powerfully described, they felt a loss of identity with their lifelong struggle with the idea of belongingness:

> We thought we were from Bhutan, and we stayed there thinking that. But they said 'No, you are not. You are from Nepal. Your language and our language are not the same.' and they kicked us out. Then, in Nepal, we went there thinking it was our place, our home. But in Nepal, they said, 'You are not *our* kind of Nepali. You are from Bhutan.' You know? They did not give us citizenship from [Nepal], and they kicked us out in [Bhutan]. We are from nowhere. (Saru, age 48, 8 years in US)

Thus in addition to the social barriers, the effects of the personal struggles and hardships faced, particularly in the camps, was consistently brought up. Many reflected on their lives as that of day-to-day survival. Others also expressed the hardships in living in the camps, as they were given lower wages than the Nepalese, inadequate food rations for many families, and little recognition from the Nepal government including citizenship and documented status. Though coming to the US dramatically improved many aspects of their lives, the feelings of loss of identity, isolation, and loneliness was also common among the discussions. Some felt the traumas they experienced affected their emotional state such as feelings of sadness or depression.

> I, you know, my mom died when I was young…A little bit after I got to Nepal [refugee camp], my father died in front of me. After three months after my father died, my sister died. My other sisters still live so far [in Nepal]. I think, now what can I do? Maybe from all of that anxiety, because I miss my father, my family so much, maybe that is why I became this sick. (Reshma, age 47, 2 years in US)

Reshma, who is undergoing treatment for her mental health problems, described some of her thoughts and feelings when she gets depressed and anxious. She described frequent headaches and not wanting to leave the house, thinking of her losses and her family still in Nepal. When she spoke of her feelings, there was nervous laughter from the group. However, at the end of the discussion, a few group members asked her if she is getting enough help and gave her some advice on doctors she could see. Though the group initially felt uncomfortable talking about mental health, once one person opened up, others were more willing to discuss the issue and share stories of people they had known who had endured similar kind of suffering. Separation from family members during the relocation process and struggling to adapt to the US society were commonly mentioned as contributing factors to depression.

> We do have people in different countries. Like one family are separated to different countries – Australia, Canada, Nepal, Bhutan, America, everywhere. So that's the other thing they feel very depressed about. And all the changes, here in the United States, makes people anxious. (Mina, age 37, 8 years in US)

> There are a lot of people with depression. Because people, like I have said before, right, they left their place, their home, came to a new place, and they still face hardships in the new place…without help. And how much can people suffer, how much can they take? And because of that, people have even committed suicide. To be honest, my friend even committed suicide. When he feels there is no help, what can he do ultimately? (Arjun, early 20s, student)

These examples showed the different aspects of mental health issues and possible causes for severe problems. Many expressed a loss of identity, that they did not belong in any society, and forming new relationships was increasingly difficult due to cultural and language barriers. After initially being resettled by the government, integration into US society became an isolating experience which had to be managed without outside assistance. The cultural distance could be seen as contributing factor to poor mental health in the community. Mental health continues to be an ongoing concern in the Bhutanese refugee community. Many expressed difficulty in adjusting to life in the US but were also hesitant to voice their concerns about their personal mental health, possibly because of the persistent stigma surrounding the issue.

Individual Level: Cultural Conceptualizations and Stigma Attached to Mental Health and Women's Health

In some ways, the social isolation kept Bhutanese refugees within their own relatively tight-knit communities. While this can be beneficial for social support, the overall lack of significant outside influence also meant that cultural norms, including stigma attached to certain health issues, was left unchanged in the community. At the

individual level, the two major health concerns raised within the group discussions and interviews were mental health and women's health. These issues also had strong stigma attached to knowledge, attitudes, and individual behavior of community members. While there was evident concern of the widespread issue of these health concerns, mental health and women's health were viewed as private, individual problems and there was discomfort in seeking help or treatment. Both issues included an aspect of stigmatization and were rarely openly discussed in the community. Community members disclosed various reasons why mental health and women's health issues may be ignored or overlooked in the community, but also recognized the urgency in prioritizing these health concerns.

As noted, though most participants indicated an ongoing concern with mental health problems, depression, and suicide within the Bhutanese refugee community, there was stigma attached to these problems which was a reflection of the norms and practices of the culture. People felt their personal problems would be a burden in their families and in their communities, and that they would be perceived as "crazy" by their close friends and relatives.

> The mental health problem among our community is really tough. Because people do not know. Even if someone has a mental health problem, um, they don't want to come forward and say it. And even if they know there are mental health services, they don't want to because in our community they can say 'oh, he's *crazy*?' so they don't want to be called that. And people don't come out about that (Deepak, late 40s, medical interpreter)

From this perspective, mental health problems are consistently viewed as prevalent but hidden. Community members feared the negative associations and labels attached to having mental health issues due to the stigma, which forced many to remain silent and became a barrier for utilizing known services and getting treatment. Another interviewee also discussed these issues in detail:

> People will fear that this person will tell another one, and that it will be like in the camps. So they fear that and so they don't open up. And they still hide the problem. Even if it is serious they don't want to tell to the family members thinking it hurts them and they feel bad and they don't want to let them know. They also feel others should not know in our society. (Gopal, late 40s, government employee)

Respondents described rumors spreading quickly within the close-knit society in the camps, especially for deviant behavior and problems associated with mental illness. The stigma associated with mental health issues is deeply embedded in the culture, and so people suffering from various types of issues feel they have no choice but to suffer alone. People with mental health disorders would be described as having to ultimately hide their problems for fear of being ostracized or hurting their family.

> For mental problems, right when that word 'mental' is used, then suddenly the thinking goes a different way, it is looked at differently, they do not consider it a sickness. People are thinking, 'what is wrong with this person?' People do have depression and anxiety in the community, but they feel they will be different than others if they talk about it. If people see their friends at the clinic and they ask,

> ‘oh what are you here for?’, if they say *mental health* then they feel uneasy. (Mina, age 37, 8 years in US)

Participants in the study recognized the importance of mental health problems in the community, but acknowledged the stigma around the idea of mental health was enough so that people may not seek treatment. Mina’s description of the uneasiness a person may feel when running into a friend at the clinic for mental health problems was also a concept others in the group agreed with. They gave examples of mental health problems in Nepal, which were often associated with extreme deviant behavior. That imagery of mental health was continued into their communities in US society, along with the stigma of being a patient of any mental health issue.

Similar to stigma attached to mental health, women’s health problems were also seen as a private, individual issue and there was much discomfort in seeking care for problems or attending doctor visits for procedures specifically involving women’s health. Concerns regarding mammograms and cervical cancer screening were raised the most frequently during conversations about women’s health.

> Especially at first, with the women in our community when going to the hospital, they were very embarrassed. They felt shame or embarrassment. They also feel they did not have to see the doctor before, so why now? They said rather than going to the doctor and doing that kind of thing [mammograms, cervical cancer screening], I would rather just die from whatever disease they are looking for. (Chameli, age 34, 6 years in US)

> Yes, I had nine kids by myself at home and I did not have to see any doctors, so I am not going to now! [group laughs] (Sita, age 64, 6 years inUS)

Much of the older generation, especially those arriving to the US initially, did not want to go to the doctor for these sensitive tests due to the lack of cultural norms for these issues. In Bhutan and in Nepal, preventive practice for women's health was not widespread, and these idea of doctors performing these kids of services was seen as a violation of privacy. Some stated they, or others they knew, were so uncomfortable with the process that they would rather not get screened, while understanding there was a risk of infection or even death. However, some of the younger respondents reported that once they learned the importance of this kind of screening, they tried to convince their older relatives.

> People don't want to go to the appointments because they feel shy. My mother-in-law still refused to do pap smear, but when I get home, I talk to her personally I tell her the importance, what are the risks of not getting it done. I talked to her at home and she said, 'ok, I'll it' (Asha, late 30s, medical worker and interpreter)

Above is an example of one of the respondents who was aware of the benefits of preventive health care and actively wanted others in the household to engage in health screenings. She later observed doctors generally do not have enough time to explain the information needed to make patients comfortable, noting *"[Doctors] don't talk about like basic information, so people decline to do it"* (Asha, Interview). Focus group participants also observed that when they spoke in-depth to the older generation of

women about why these tests are performed, they became more willing to attend the appointments.

> I would say even now, maybe only half the people here really think it is something like 'I have to do this, this is something is for my health, I should not be embarrassed.' In some households with a lot of sons or older men, they will be embarrassed and if they need help getting to the appointments they would rather not do it, they will cancel it. If there are daughters, daughter-in-laws at home though, it helps. (Chameli, age 34, 6 years in US)

Participants agreed that when there is another female at home to help them or support them to handle their feelings of discomfort or insecurity, it is more likely they will go to their appointments. The younger generation felt more at ease with these issues, and emphasized the need for the community to overcome the stigmatization to increase the health of the female elders. They spoke to their mothers and grandmothers about the necessity of check-ups such as pap smears, but also indicated that there was not health information provided for the community to engage in these types of healthy practices. The youth and family members were the main source of information and encouragement for women's health.

Though participants agreed they were a close community that helped each other, most still kept women's health and mental health concerns within their immediate families or to themselves. These issues were seen as important and that needed to be addressed by health professionals, but also difficult to discuss. Respondents who had some experience in the health field, either as interpreters, medical assistants, or close

relationships to doctor or nurse friends were more comfortable bringing up these issues, and felt the community would benefit from more discussion and openness towards mental health and women's health.

Discussion

The findings of this study provide an important overview of health for both Bhutanese refugees and implications for larger vulnerable refugee communities in the United States. First, this study and other research has demonstrated that taking into account the personal and social history and attributes of an individual in the context of their community both pre- and post-migration is important because it shapes the way they may view or conceptualize aspects health or health care access (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). Individual experiences taken together can provide a shared perspective on the prioritization of health issues in the community and highlight specific problems and needs for health promotion, though this strategy is not widely used in the development of health promotion activities (Novilla, Barnes, Natalie, Williams, & Rogers, 2006). In the case of Bhutanese and other refugees, at the individual level, collective trauma of forced relocation, discrimination in health systems and social position in host countries or camps based on refugee status is necessary to consider, as this sets them apart from other new immigrants and can heavily impact their current health practices and behaviors (Nazzal et al., 2014).

Second, language and cultural competency shortcomings by medical providers at the system level can have serious consequences for refugee groups, who have already shown to approach the host country's doctors and health care services with caution and

possible mistrust (Majumder, O'Reilly, Karim, & Vostanis, 2015). Gaining a cultural understanding can impact the conceptualization and understanding of health, and cultural expression and practices of health management and personal health behavior (Xiong et al., 2016). Thus, programs which seek to assist refugees overcome language barriers, such as employing medical interpreters, should also strive to train culturally informed individuals with a deep and empathetic understanding of the refugee group. In line with the findings from this study, other research has shown medical interpretation goes beyond linguistic accuracy and has an impact on patient trust, degree of family members' assisting in medical visits, and doctor perspectives on patient understandings of visits (Zendedel, Schouten, Van Weert, & Van den Putte, 2016). Data consisting of health outcomes of highly trained culturally competent medical interpretation among refugee groups, including Bhutanese refugees, is still not widely available. This study demonstrates the need for more attention on these highly vulnerable groups whose health can be significantly impacted by the misdiagnoses, miscommunication, and mistrust currently found in many interactions with medical interpreters in the health care system.

Third, at the community level, integration into society is a long, arduous process and the culture shock of being in one type of society to another, such as communal to individual-based, can be difficult to manage. Studies examining refugees in European countries have also found the lack of social integration can contribute to psychological impairment and that refugees continue to have disadvantages in access and utilization of available health care services (Schick et al., 2016). Understanding the complex social structure of US society is a learning process, but interaction with outside communities

can be greatly beneficial for health and well-being (Gaertner et al., 1999). As with many new immigrants and refugees, stressors of being in a new place, feeling alone, and having to quickly adjust to many different changes has shown to increase risk for mental health issues (Betancourt et al., 2015). Targeting social integration by exposing community members to outside resources and increasing comfort and confidence with cross-cultural interaction can aid in reducing feelings of isolation and loneliness after arriving to a new world.

Lastly, in the US, Bhutanese refugees have high rates of depression and suicide, so mental health is a significant area of focus for research in these groups (Ellis et al., 2015). Many refugees in general come from close-knit communities with shared resources, information, and social networks. Discussing sensitive health issues will likely be uncomfortable and fear of being negatively labeled, ostracized or humiliated for certain treatment can be a strong influencing factor which can prevent seeking care. However, due to the unique conditions of refugee migration, which can include separation from families, impact from violence or war, and exposure to post-migration stressors in the US, refugees are especially at increased risk for severe mental health problems (Nazzal et al., 2014). Health programs which promote the normalization of commonly stigmatized health issues would also greatly benefit vulnerable groups

At the individual level, mental health of refugees have consistently been found to be an important priority across numerous studies, as depression, anxiety, post-traumatic stress disorder, and suicide or suicide ideation affects affecting an overwhelming amount of the refugee population, including Bhutanese refugees (Watters, 2001; Mitschke, et al.

2013; Nelson-Peterman et al., 2015; Subedi et al., 2015). The persistent stigma for sensitive health issues can be reduced through health promotion and public health programs which aims to normalize health concerns end emphasize prevention for address common health problems (Thornicroft et al., 2016). Engaging the community in conversations about potentially sensitive topics such as mental health or women's health should be approached carefully, and can have significant benefits to the community. As seen in this study, as focus group participants discussed their concern over these issues, they also started helping each other by exchanging information on resources and encouraging others to seek help for mental health or women's health concerns.

Increasing knowledge and awareness of common health problems and implementing culturally relevant programs based on needs specifically identified by the community can vastly improve overall health. Health program planners should consider refugees' traumatic past and potential difficulty in adjusting to language, culture, and a new community when coming to the United States. Refugees have a complex history which can include patterns of discrimination, unstable cultural relationships with countries which hosted the refugee camps, and unique cultural or linguistic characteristics. It would be beneficial for researchers to spend time to gain a deep understanding of cultural norms in order to provide effective health education and raise awareness for preventable illnesses and problems in the community. Holistically addressing health issues identified by the community and aiming to reduce stigma and normalize health concerns can improve preventive and healthy behaviors in these groups for the well-being of individuals and their communities.

Limitations

The limitations of this study included a small sample size of a very specific refugee group. However, basic similarities in past trauma, issues with incorporation into the United States, and limited access and availability to health resources may be similar across vulnerable groups. Additionally, this study was open to community members of all ages, though throughout the group discussions it became apparent that health issues facing aging individuals are different than younger generations. Older adults have survived through living most of their lives in Bhutan, the subsequent exile into Nepal, and learning to live a completely new life in the United States. Future research focusing only on their stories and lives would also contribute rich detail and in-depth knowledge on the process of forced migration and health patterns of behavior throughout the life course.

CHAPTER IV

PROGRAM RECOMMENDATIONS FOR PROMOTING HEALTH IN BHUTANESE REFUGEE GROUPS IN THE UNITED STATES: COMMUNITY VOICES FROM WORCESTER, MASSACHUSETTS

Introduction

Existing disparities in delivering health services and accessing resources among ethnic minority groups in the United States occur due to barriers such as limited English language ability, inadequate cultural adaptation of health programs, and low health knowledge and literacy (Carroll et al., 2007). Marginalized groups have less access to health resources and may be excluded from or less likely to participate in health promotion programs (Laverack & Labonte, 2000). Furthermore, forcibly displaced populations experience countless difficulties in the process of migration, including persecution due to religion, ethnicity, or political conflict (Grove and Zwi, 2006). Refugees in particular may be exposed to war, violence, or other traumatic situations and face multiple journeys to foreign lands through extended and complex processes to even obtain refugee status and safety (Grove and Zwi, 2006).

For the selected refugee applicants who are approved to officially resettle in developing nations, there are still a wide array of health disparities which occur. In the United States, many refugees have limited knowledge or access to available health services, live in poverty, and face economic, cultural, and language barriers (Edberg et al., 2010). Refugee groups resettled in the United States have an increased risk of poor

health, underutilization of health services, and chronic physical and mental health problems (Palinkas et al., 2003; Mitschke et al., 2003). Additionally, the process of migration and resettlement can be especially burdensome, as many refugees may be separated from their families and have difficulty adapting to a new environment, which can lead to increased stress, depression, and anxiety among these groups (Mitschke et al., 2013). Consequently, they may be less likely to engage in preventive behaviors or have health promotion programs tailored to their needs once they have arrived in the US.

While the Office of Refugee Resettlement provides transitional assistance to new refugees, self-sufficiency is required in various socioeconomic aspects of refugees' lives after a certain amount of time, such as employment services, obtaining citizenship, or continuation of health care services (Betancourt et al., 2015; Bruno, 2015). This has made it increasingly important to develop relevant health promotion programs in order to build community strength, after initial resettlement and continue working towards positive health status for marginalized groups. The importance of incorporating narratives to health inequality research and the utilization of participatory models to address these inequities has been emphasized in social science research; such research can provide communities with a sense of agency and control over their health and knowledge of health resources (Morrow, 2001). Thus, speaking directly to community members about their specific health needs and collaboratively developing strategic action plans to improve health can be a productive and efficient way in to increase access to exiting health services, and improve community health.

Studies which have exclusively focused on interventions to improve refugee health have found continuing physical and mental health problems in the community, limited knowledge or awareness of health programs or services, and high risk for chronic health conditions such as post-traumatic stress disorder, diabetes, certain cancers and obesity (Misra et al.,2015, Mitschke 2013; Vonnahme, 2015). Limited research exists which applies qualitative methods to collect information directly from community members and leaders about general health concerns, and few studies have specifically sought to obtain program recommendations from the Bhutanese refugees. Community members' contribution in program planning and design, as well as collaboration and support for active involvement in program implementation has been shown to be beneficial for increasing participation in health promotion programs and health behavior change (Laverack & Labonte, 2000).

Through focus groups and interviews, this study will utilize a qualitative phenomenological approach to understand the embedded meaning that is created through individual lived experiences to uncover the core aspects of the needs and perspectives of the community (Starks & Brown Trinidad, 2007). This research uncovered various areas of program recommendations from the perspective of the community and ways to make future programs more culturally sensitive and relevant to the Bhutanese refugee population. The purpose of this study is to highlight the immediate needs of the community, categorized based on program recommendations, to provide a foundational bases of appropriate elements of future health promotional activities directly supported by the community. These program elements can be integrated into future program

development in order to effectively work towards health promotion and disease prevention in the community.

The research question to guide this study is as follows: What are recommendations given by the community for relevant programs components which may effectively promote health for Bhutanese refugees in Worcester, MA?

Methods

Study Site

Data collection occurred in Worcester, Massachusetts, a city in central MA with a large diverse refugee population. This study utilized qualitative methodology which included six individual in-depth interviews with key informants and community leaders, and four focus group discussions with Bhutanese refugee women, for a total of forty-six participants. Focus groups were conducted in Nepali and at a convenient location for participants; three focus groups were conducted in participants' home, and one focus group was conducted in a shared space of a nearby Hindu temple. Each of the focus groups included 8 to 12 individuals, for a total of 40 participants.

Ethical Approval

This study was approved by the Institutional Review Board (IRB) through the Division of Research at Texas A&M University.

Data Collection Procedure

Recruitment. Participants were recruited through snowball sampling and word-of-mouth, and multiple visits to Worcester as well as interaction with the community and community leaders helped to establish rapport and trust with community members.

Voluntary liaisons in the community assisted with recruitment and organizing focus group times which facilitated participation in the study.

Focus groups. Participants in the focus group study were adult females (age 18 years and older), who were Bhutanese refugees of Nepali ethnicity and currently resided in Worcester, Massachusetts. Forty total participants were included in the focus group portion of this study. Participants were asked to give verbal informed consent for audio-recording. Information regarding details of the study was also distributed. No participants refused to take part of the study. They were also informed that they could leave at any moment of the study or decline to answer any questions, including those on the demographic questionnaire. Each focus group lasted between 1-2 hours with 8-12 participants each and all were conducted in Nepali.

At the completion of the focus group discussion, participants were given a confidential demographic questionnaire to gather general information which was available in both English and Nepali. Thirty-six questionnaires were submitted with most answers complete. Overall, the youngest member of the focus groups was 24, and the oldest was 80. Most participants lived at least 15 years in the refugee camps, and had lived in the US for a minimum of close to 1 year. The majority of participants did not have more than 8 years of formal education, and also felt they knew little to no English. Additionally, self-reporting "fair" health was the most common response across the focus groups.

Interviews. The six participants for the key informant interviews were adult (age 18 years and older) Nepali-speaking Bhutanese refugees who had given informed

consent at the beginning of the study for audio-recorded sessions. The key informants were known community leaders with connections to the local health care system or participation in social activism for the Bhutanese refugee community. Both females and males were included in the interviews, with half of the total participants being female. Ages varied from 20's to late 40's. Interviews lasted on average one hour and were conducted at a setting based on the request of the participant, which was always at their home. The interviews last forty minutes to one hour and were conducted in the language of choice of the participant, which was majority English and one in Nepali.

Data Analysis

Focus groups and interviews were transcribed verbatim in the language conducted by the researcher who is fluent in both Nepali and English. For the protection of the participants, only pseudonyms were used for all transcripts and final reports. All Nepali transcripts were translated into English. To maintain consistency as well as to ensure original meanings of the participants, audio transcripts were also back-translated and reviewed by a bilingual certified medical interpreter.

Data was analyzed using ATLAS.ti qualitative software. Data for this study included interview and focus group transcripts, memos, and field notes. Data from focus groups, interviews, memos, and notes from participant observation were coded and re-coded, and categorized to consolidate data and meanings based on shared patterns (Saldaña, 2015). These codes were conceptually categorized and constantly compared and analyzed. A coding schema was developed through an inductive coding process including reoccurring codes which had been collapsed into broader categories. Notes and

memos were included throughout the coding process to document commentary. Thematic concepts emerged during the coding process which were organized based on commonalities of codes (Saldaña, 2015). Final themes generated were then defined and presented as the results of the study with supporting quotations and observations (Saldaña, 2015).

Results

Completion of data analysis yielded four major themes, which are presented as community recommendations for program components to improve health. The follow section describes the recommendations for community health improvement from the perspective of the participants, as well as the incorporated factors for each recommendation as discussed in the focus groups and interviews with the Bhutanese refugee community. The recommendations include: 1) increase access to health information and education; 2) utilize existing social support from the community; 3) implementation of community health discussion groups; 4) train and employ community health advocates.

Recommendation 1: Increase Access to Health Information and Education

Without formal health programs or health education in the community, participants obtained most of their health information through advice from medical professionals. This was evident through the diligence of adhering to medical advice by the community. However, members of the community with more education, or who had experience in the health care system, noticed the limited amount of time in which doctors were able to give medical advice to patients. Only receiving health information

from visits with medical professionals was seen as insufficient, and overall the community expressed the need for more access to health information.

Many participants also engaged in certain health behaviors through observational learning or modeling behavior, noting the types of disease afflicting others and making changes based on their perceived risk. Though limited health promotion programs were available in the local area, community members seemed to benefit from learning from each other through informal means, which points to another possible channel for health promotion and education for Bhutanese refugees in the area. The following section details the factors contributing to the recommendation for an increased access to health information and education in the community.

Limited avenues of health information from medical professionals. Participants with experience or training in the health care industry expressed concern about the community members receiving almost all of their health information from the doctor, noting there is not enough time in one doctor's visit to convey all needed health information for the patient's health. The health information from medical professionals was based on the advice given after a medical examination or treatment for a health problem, usually in an ER or urgent clinic where members of the community primarily receive most of their health care. Generally in this kind of fast-paced environment doctors may not have much time to devote to health education for the patient. For example, Asha, who works as a medical assistant, explained how this affects health in the community:

> I think just with some education, it helps [improve health]. Because when you go to the doctor's office you have like 15 minutes to talk with the doctor. They have to examine you, get your vitals, order the tests, within those 15 minutes, so the doctor - they don't have much time to talk to the patient. Like for a pap smear, a lot of the people who come from the other countries, they don't know what is happening, why it is done, and there is not enough time to explain, so they decline to do it. Having general information of these things, health knowledge…there is not much of that in the community. And there are a lot of information that people need to know, because they come from very different culture. (Asha, late 30s, medical worker and interpreter)

Others interviewed with advanced education or experience in health care felt health information should be supplemented with other reliable sources. As Asha observed, patients may decline to do preventive practices such as cervical cancer screenings, and may not fully understand the procedures or reasons why such examinations are beneficial to their health. Additionally, language, practices, and behaviors can be vastly different from one group to the next. Having general information through programs and health promotion which is needed for good health, and that specifically cater to the Bhutanese refugees' culture, appeared to be largely absent from the community

Though the information obtained from a visit with a medical professional was limited, it was taken seriously and adhered to frequently. One respondent summarized the community experiences in the following statement:

> People in the community, they really listen to the advice that the doctor says, very much so. So, they will do it, they will do what the doctor says if they have given them advice on what needs to be done for health. Everyone will. If they are told by the doctor that they have to walk, then in their mind that is something that they *must* do. (Chameli, age 34, 6 years in US)

Medication adherence, exercise, and other health advice was seen as necessary and imperative if coming from the doctor. A respondent in another focus group further gave their own example of following the doctor's advice:

> I do not have diabetes but I have been careful about what I eat because the doctor was saying I have this much sugar and cholesterol levels and that I should start being careful…so now I am more careful with the food that I eat. Though maybe I could do more. (Nirmali, age 45, 5 years in US)

Respondents did not have much additional information from the doctor on advice healthy habits, such as the type of foods to eat to replace meals, examples of food low in calories or cholesterol, or other details on changing her eating behaviors. When further probed about other sources of health information, Nirmali had responded, *"No, there is not anywhere else where I get the information for my health, the doctor will tell you need to do"* (Nirmali, age 45, 5 years in US). Others in the group expressed agreement with her statement.

Medical information which was more culturally informed, such as from traditional healers, were still similar to health information received from a US doctor. While useful, the information was for prescribing cures to ailments or addressing the

immediate need for medical attention. Nevertheless, traditional healers were sought out by the Bhutanese refugees as a secondary option after going to the US doctor, as there is established trust with healers in the community.

> First, we will go to the hospital, then the *Dhami Jhakri* [traditional healer]. The doctor will tell us things, but if what the doctor tells us to do is not working, then we decide that we are going to the *Dhami.* Usually that will help. It has been the tradition and culture for a long time. (Anita, age 52, 5 years in US)

Traditional healers were frequently brought up throughout the conversations with participants, who mentioned they sought help from healers if treatment and medicine from hospitals appeared to be ineffective. Those who ended up seeing healers for ailments gave stories of successful treatments and were satisfied with their experience. The practice of seeking health care from traditional healers was more commonplace in Nepal, though a few healers do practice in the community in Worcester. However, these healers are also used more for treatment-based care, and are mostly requested during emergency cases when other medicine appears to be ineffective. Health information from healers, like doctors, was seen as useful for advice on curing illnesses, but did not extend to everyday behavior for long-term healthy lifestyle practices.

Informal learning of health behaviors. The other major channel for obtaining health information or education was through informal means, by observing behavior of others or through the perception of risk based on friends and family in the community. Many participants said they changed their health behaviors because they had seen or heard others being affected by certain illness (such as diabetes) or becoming healthier

through certain practices (walking, eating healthy, etc.). Focus group members reflected similar statements as the following: "*Both my husband and my mom have sugar [diabetes]. And that makes me afraid, that it could happen to me. So, I try to eat better and walk more."* (Ritika, age 30, 4 years in US).

Most participants in the discussion groups either had diabetes (also referred to as "sugar") or knew someone who did, and many expressed concern over the possibility of having to deal with this kind of illness. Ritika's example shows her changing behavior from observing from others what needs to be done to prevent the onset of diabetes. Others also agreed they were seeing more changes in the community just based on knowledge from experience or observation.

> Knowing things like it is good to walk for blood circulation, younger people our age, they know exercise is good and it is good to run a little in the mornings, going to the gym, that kind of thing. Even without being sick. And with older people even from their own experience, walking a little bit each day makes them feel better. And sitting at home makes them more tired or sore, so they walk more. (Anu, age 56, 6 years in US)

This quote explains health practices spanning two generations and different types of motivations for each. The idea of exercising regularly was common practice among younger adults (ages 20s-30s). Among older adults and elderly population, it was demonstrated that an aspect of common knowledge influenced health behavior, as it was learned through life experiences or through general information passed informally within

the community. In a different focus group, an example of change in eating behaviors was noted:

> We usually would cook with so much oil, but now know a little more we should eat less sugar, less oil or fat. Now with everyone having diabetes they are a little more aware. My father-in-law just came [to the US] and I remember he used to love food that was cooked with lots of oil and spices, but now he says, 'it's better to use less oil with cooking, it's better for you'. So like that, maybe learning from others, people are becoming more aware. (Nina, age 48, 5 years in US)

Nina suggests that awareness is spreading in the community and also observes a changing practice within the whole community, such as cooking with less oil and sugar as this was observed to be contributing factors towards diabetes. It is possible the increased knowledge could have been from community members passing down advice given by medical professionals or simply noticing the cause-and-effect of healthy and unhealthy behaviors on an individual. The informal networks of health communication helped to increase health knowledge and practices, and amplifies the effectiveness of social ties within the Bhutanese refugee community. The recommendation to incorporate programs which build upon the strength of social ties in the community can be seen in this community as an effective route to increase the amount of health information and education to improve health overall.

Recommendation 2: Utilize Existing Social Support from the Community

The strong social support seen among Bhutanese refugees was consistently cited as one of the major strengths of this community and is a powerful asset to encouraging

community involvement and participation in health programs. Community members gave many stories of volunteering much of their time to helping their own people, and in many ways felt it was necessary in order to survive the potential hardships and challenges of a new and relatively isolated life in the US. Social support was viewed as embedded in part of the culture, as many expressed their natural tendencies to help their own people. This altruism revealed the social network of the Bhutanese refugees as a vital part of surviving life in the United States. The quote below in an interview expressed the general sentiment shared by the majority of the participants and further demonstrates the strong sense of community and importance of community support for this group. "*The life in a village, in Nepal, if one person gets sick then hundreds of people would be there to help. There was that kind of thing; it does not happen here. If you are not part of a community you have no one here*" (Arjun, early 20s, student).

Culturally embedded altruism in community. The idea of an existing altruism was brought up in the study to explain how the members of the Bhutanese refugee community look out for one another, without expecting anything in return. Respondents gave examples or perspectives on community support and their personal ideals behind the need to help each other.

> I like helping others. I'll do anything for my community. If someone needs a ride to the hospital in the middle of nowhere, if I have a car, I will help them. I was raised in this [Bhutanese refugee] society and I need society, is what I say […] I feel that in the society, there should be non-profitable help for others, that there should be that kind of contribution. (Arjun, early 20s, student)

In this part of the interview, Arjun became more emotional when discussing his ties with the community. As a student, he spent a lot of his time outside of school to help his community, and his parents' local involvement with religious organizations gave him exposure to various community interactions. He felt there were people and organizations who exploited Bhutanese refugees and that they had limited non-profitable contributions from outside societal influences. His interest was in the health of the community, and gave several instances of providing transportation, helping with translation in clinics, and assisting caring for sick grandparents in his home.

The altruistic nature he describes was also reflected in other interviews, where respondents described their services in helping the community as something which was almost second nature. Respondents were passionate about describing the help they provided the community and were humble about the extent of their work. Many spent time outside of school or work to provide assistance in the community. Other participants gave a number of examples showing the way they help their communities in different aspects of their lives.

> I'm going to college, and I help Bhutanese students, the Bhutanese students that want to learn. I encourage them to go to college if they ask. A lot of them, they call me for information, where they can go. I like to help and be involved in community work. (Deepak, late 40s, interpreter)

Some respondents who obtained higher education or advanced training in different areas spoke of immediately going back into the community to help others learn how to succeed in the system. Those which discussed helping other Bhutanese refugees

mentioned how their time helping the community was on a volunteer basis. In the interview with Deepak, above, he spoke about his part-time work as a medical interpreter, his leadership role in the local Bhutanese refugee association. He held a full-time job unrelated to these other positions, but became more enthusiastic and animated when discussing his various roles in helping the Bhutanese community. He was among the first Bhutanese refugees in the area, and like other participants in the study, was using his knowledge and experience to help others overcome barriers and succeed in their transition.

Other respondents also utilized their understanding of US society to help the community as a form of informal health promotion, spreading knowledge and awareness of health services based on their experiences. Riya, a college student, spent almost half of her life growing up in the US, and became a leader among the younger girls in the Bhutanese refugee community through her volunteer work with local events and activities. She described her growing presence in the community and how she made positive influence on the girls through social media networks. She gave an example how she helped others:

> I've also helped a lot of younger girls while doing other kinds of help in the community, like I help them know about getting birth control or talk to their doctors about birth control and stuff like that because it's just it's a conversation that's not happening anywhere else. I think our community is just so shy about talking about these kinds of things. So I do what I can. (Riya, early 20s, student)

Riya described approaching sensitive health topics which were found to be often stigmatized or taboo in her community. Throughout the interview she detailed ways she has helped young girls, sometimes in crisis situations, with sexual and reproductive health issues that they did not feel comfortable speaking to their parents or other adults. She was seen by others as a trusted and influential community member, and was connected to other Bhutanese refugee organizations outside of Massachusetts. As a college student she also mentioned how she did not have enough time to help as much a she would like, and her involvement in the community under the influence o fher parents who were also actively volunteering in in Bhutanese refugee community.

Personal examples of altruism in the community were consistently regarded as examples of community strengths and how the Bhutanese refugee community advanced as a unity. Community leaders served the community through social organizations, building confidence and teaching skills, and sharing information and awareness about available support and resources for different concerns. Most respondents in the interviews repeatedly said they wished they could do more for the community and were supportive of any health promotional programs.

Reliance on the community for survival. Part of helping the community stemmed from the notion that "we're all we have" or strong feelings of relying on the Bhutanese refugee community for survival and success in the United States. Participants believed that they were the strongest asset to their community, and emphasized the importance of having their "own people" to help them through the transition into US society. For those who were first to arrive from Nepal, the growing community support

became especially apparent, and many described this as one of the only sources of significant help in the area.

> It was hard for people who came first, the ones that were here earlier. But now, there's everyone here. When we go to places, there are people there to help, there are our neighbors, our own people. We don't have to ask strangers or outside organizations. We are so far away from the place we knew, and we are all we have for each other. So we are all helping each other. (Suki, 38, 6 years in US)

In this focus group, Suki was in one of the earlier families who arrived directly in Worcester shortly after the resettlement program begun. She had previously spoken of the struggles faced without having other Bhutanese refugees at first and the need for community ties above outside help to navigate a new society. The shared commonality of having to find a new home created a sense of mutual dependency where they felt they were all they had for one another.

Other participants specifically noted the impact community support had on accessing health services, and how over time, acquiring skills has led them to increase their ability to help others.

> Using the bus, going to the appointments, it was hard at first, there was not any help. But now, knowing a little more English, we have helped a lot of families. Taking them to the doctor, saying here is where you go, this is what you do or say here. It helps when you have your own people nearby. (Saru, age 48, 8 years in US)

> A lot of Bhutanese come here and feel anxious and a lot do not know a lot of new things. For us, we can help them to say what they are trying to say so the doctor understands. We can tell them the hospital is here, this is how you get there, we can take them there and help them. (Asha, late 30s, medical worker and interpreter)

Saru, also one of the first to arrive with her family to the US, had many stories on the types of difficulties faced without feeling part of a community. She notes that learning English, navigating the bus system, figuring out ways to express concerns in the health system, and providing guidance for others has been important for her family as well as others, so that they do not have to manage similar hardship. Similarly, in another interview, Asha also speaks about the anxiety of arriving to the, and how this be eased by reaching out and helping the newcomers in different ways, such as communication with health providers and transportation to hospitals.

Many stressed the importance of having other community members nearby throughout the group discussions. For example, in a different focus group, Radha expressed similar sentiments from her experiences. She came with her family after there had been a growing number of Bhutanese refugees in the area. She explains:

> We did not have problems coming here because we went to our in-laws who helped us right away. If we were to give suggestions for others, I would say to go where there are your own people. Find the addresses and go there, because they will help with getting food, transportation to the hospital, whatever you need. (Radha, age 40, 7 years in US)

While some of the conversations diverged from specific health issues, the importance of community ties and philanthropy was demonstrated through numerous examples of community support throughout the discussions. These examples arose from questions regarding recommendations to build on existing community resources to improve health. Having a strong sense of community and social support affected various aspects of the lives of the Bhutanese refugees, and the effects on health were seen through examples of giving advice for navigating health care system, providing transportation to health facilities, and discussing sensitive health topics with friends or mentors.

Recommendation 3: Implement Community Health Discussion Groups

The strong sense of social support can provide a foundation for other forms of health information accessibility, such as through the implementation and maintenance of community health discussion groups as suggested by participants. Community health discussions were viewed as a potential setting for safe space where community members could gather to talk about sensitive health issues as well as a place for pressure-free health education, or education about general health concerns without the time constraint and limited information from doctors' offices. This was also seen as a way to gain information, encouragement and support, as well as outside expertise to help with understanding basic skills for health improvement and obtaining health services.

Gathering place for sensitive health topics. Community health discussions were viewed as a way to gather individuals into one place to feel comfortable and secure in talking about sensitive health issues. This was seen as especially beneficial for

women, so that they can share ideas, interests, and concerns about health topics that may be difficult to bring up with others. For example, Mina gave some general guidelines on what she would want to see in this type of group:

> Having people to trust, it is important. There are many things that are uncomfortable to share with your husband. But you can tell your female friend, right? So making a time to get together, to talk with each other about specific things would help. And make sure people do not gossip about others problems. Saying that everything we talk about stays in this room so that they have the trust to talk about their problems. (Mina, age 37, 8 years in US)

The key points of the suggestions addressed major problems which could arise from revealing sensitive information in a small and close community. The emphasis on trust, confidentiality, and keeping a focused discussion was seen as a prominent way to help others to open up about their problems. Participants also agreed that having female friends and support among this type of group could help bring women's issues into focus while ensuring a safe space for discussion.

Some of the sensitive health topics discussed were problems of domestic violence or mental health. For example, in an interview Riya explains:

> There is domestic violence that goes on, but people don't talk about it. There is this fear, what will happen to my family, what will others think? Or it might mess up the relationship with my husband or family or that kind of thing. It would really help if people had somewhere to talk about this stuff. (Riya, early 20s, student)

A few women in the focus groups also mentioned domestic violence issues in the community that they had heard about or encountered. Riya observes that it does occur but is difficult to discuss due to the possible consequences on the individual, family, or community. She suggests a place to talk about these issues without having to feel judged or a place where women would feel comfortable would help the community. In a focus group, Chameli highlights the impacts such gatherings could have on the community:

> To improve the health, we have to come up with some kinds of activities that makes people confident with doctors, or other health workers, so that they will be able to express their problems. Like the women or other people, who maybe can be hiding their problems. Especially with mental health, I think we need to educate people. All the whole family members need to be educated. (Chameli, age 34, 6 years in US)

In this description, Chameli directly related activities which could improve the overall health of the Bhutanese refugees in the area. She emphasized the importance on educating community members about mental health, noting the affect mental health has on not only the individual, but family and relationships with others. Others in the group also thought it would be a good idea to have a place to talk about mental health where they could share concerns and understand ways they or their families could help someone that they knew which might have a mental health problem.

In different interviews and focus groups, respondents had also brought up the importance of family involvement in helping to improve mental health, and how one of the biggest challenges faced by those suffering from mental health problems was feeling

ostracized or being viewed as “crazy” by the immediate family or close friends. In an interview, Asha also draws upon the idea of health education for mental health problems and ways the community could benefit.

> I think they don’t bring [mental health] up during the doctor visits. If we could do some education to like, how to address it, and then what can happen if we address it, and what kind of treatments are available. You know what I mean? We don’t have that kind of education in the community. (Asha, late 30s, medical worker and interpreter)

Asha, who has had some experience with community health outreach, explained that mental health is generally not viewed as a sickness to discuss with the doctor, and felt more education in the community is needed to improve the and knowledge of mental health, and the advantages of getting help or treatment. She felt that increasing mental health education and discussing mental health issues in the community would help others bring up their concerns with doctors or health professionals.

Pressure-free health education. Participants also felt a group discussion would give them time to discuss issues that they may not be able to at the doctor’s office. Since most of their health education and health promotion came from limited time at a hospital or clinic, meeting in a group setting could reduce the pressure and urgency that can be implicit in a doctor’s office. Mina explained:

> Maybe having like a training, I think those would be helpful. There is not a lot of time with doctors to learn all the information. But there are a lot people that once

> they understand what [the health problem] is, they will want to make the improvement to their life. (Mina, age 37, 8 years in US)

As mentioned by others, Mina noticed a lack of time with doctors to learn health information that could change health behaviors. However, she also pointed out that when people had better understanding of the health issues would be more motivated to communicate about these issues and collectively address them. Another participant in the focus group agreed this would help, and detailed other aspects of a gathering place for the community members:

> We could maybe meet once a month somewhere, where everyone makes some time for just sharing our own concerns. Getting a get-together or small group where people can talk about their health problems or hardships…Where people can ask questions about what do to, how to do it... Then people can talk to others and see what others are doing, and go home and talk about it. (Sabita, age 53, 6 years in US)

Sabita emphasized several points which sparked group discussion and contribution to the conversation. She noted the importance of spending time to discuss common health concerns such as medical appointments, and insurance questions within groups Engaging in peer learning and support could help normalize health issues in a shared space, and encourage others to meet regularly so that they can discuss health at their own pace. This relieves pressure from having to learn everything at once and guarantees a specific time and location where community members can talk, learn, teach others, ask questions and discuss solutions.

In a different focus group, some participants also suggested introducing outside help from other agencies, organizations, or health professionals to improve access and connections in the community.

> If you have a gathering in some area, and somebody give the health information in the language they speak, that would be more helpful. People can feel comfortable to ask questions. There can be some people coming into the community, talking, like from different health agencies. (Anita, age 52, 7 years in US)

Anita and others in the group were open to the idea of learning from health experts in the field, such as local health agencies, and having them educate the community on available services, addressing community health concerns, and maintaining support in a culturally appropriate way, such as presenting information in their language.

Overall, participants expressed enthusiasm at the idea of having a designated time and place to get together and voice their concerns and help one another. They were also willing to receive information and participate in health programs initiated by individuals or organizations from outside of the community to better understand how gain access to relevant knowledge and available resources that can help improve the community's health. Their major concern was whether the program was culturally and linguistically appropriate for them.

Recommendation 4: Train and Employ Community Health Advocates

Participants elaborated their ideas on community health promotion and discussed implementation strategies. On several occasions, participants indicated they needed an

organizer to help get them together, and detailed the potential advantages of a trained community advocate, who were bilingual and represent their interests. This was especially important to those who did not feel comfortable with speaking English or unware of existing programs or policies. As a potential resource to connect community members to resources and to assist with general health concerns was a community advocate would build on the community strengths of high social support and communal culture of the Bhutanese refugees.

> To make it easier, in our community we would need a type of person who could speak both languages, from our own community, you know? Someone where this is their main job. They could be helping out the families who needs more, like giving them more time and attention, teaching them to do things, helping make doctor appointments and taking them there. They would be like a social worker but from within the community. Someone like that would help everyone. (Chameli, age 34, 6 years in US)

While the community values the altruism and support of others within their group, the participants also acknowledged the difficulty of balancing time for community activities work or school, or other obligations. Like Chameli, many focus group participants described how it would be helpful if a community advocate would work for the community as their primary position of employment to exclusively prioritize the needs of the Bhutanese refugees. Participants noted this would particularly benefit those who are newly arrived, low English proficiency, a few number of close contacts, and have limited transportation to health services.

Others went into more specifics about health barriers and ways in which the advocate could help the community overcome these barriers.

> I would like if there was someone that can tell us exactly how to talk to the doctor, what to tell them so that we get what we need. I do not know how to speak [English]. There are interpreters at the health center but not someone in the community. We need someone to help those of us who do not know anything. (Nina, age 48, 5 years in US)

In this example Nina says her inability to speak English contributes to difficulty with communicating with the doctor. Many participants had previously discussed the issues they faced with medical interpreters at hospitals. Participants agreed that beyond medical interpreters, who were often Nepalese rather than a Nepali-speaking Bhutanese refugee, someone was needed from within the community who had first-hand knowledge of the specifics of Bhutanese refugee culture, language, and health needs.

> Sometimes like, for the family who doesn't know how to speak English, who don't have the transportation at all, it takes time to learn. So it would be great if some kind of community health worker could help, they could help set up the appointments, call the ride for them to get to the hospital, that kind of thing. If they can speak both languages, that would help. And I don't think there is something like that happening right now. (Gopal, late 40s, government employee)

In this interview Gopal also indicates the importance of helping families who do not speak English and have limited community resources. He also gave suggestions on

having someone with access to knowledge on existing services, being bilingual, and believes this type of position would greatly help the community.

In a focus group, one respondent also addressed the need of having a connection to existing services as important, especially for women in the community. Asmita describes:

> For those who do not know what to do, having an organization on behalf of us women would help. Someone who was there to connect with other places. There's so much going on within people's homes, to know how to get out and go to the right place; that really would help. (Asmita, age 37, 3 years in US)

Asmita expanded the description of the community advocate to include an organization that would help represent the women in the community. She alluded to previous conversations of stigmatized health problems such as mental health, domestic violence, or women's health issues. Other participants repeated the idea of having their particular concerns reaching the appropriate service, facility or resource. This also suggested that community members' felt they were currently not well-connected to various health services in the community, and that their concerns were not being handled effectively. The need for an advocate can also include the need for a representative organization with similar qualities sought in the advocate – knowing both languages, cultures, and other shared similarities, so that the community feels adequately represented and cared for, while simultaneously improving access to health resources and overall health in the Bhutanese refugee community.

Discussion

It is increasingly important to implement health programs which build community capacity, self-sufficiency, as well as empowerment for communities through increasing accessibility of available resources and dissemination of knowledge and awareness through health promotion. This is especially necessary considering the Office of Refugee Resettlement has a limit on the amount of time and resources offered to new resettled refugees (Vergara et al., 2003). Communicating directly with the community to obtain their input and perspectives on strategies to improve and maintain health can be invaluable for public health professionals in designing culturally appropriate and effective programs. The findings from the current study has the following policy implications.

First, initially collecting data from community members gives deep insight of the health needs and existing resources of the community. For example, the channels through which community members obtain health information and health promotion are important to consider, as health information may be communicated appropriately on the surface (i.e. through health clinics and doctor's offices), but the information received may be is limited, culturally irrelevant, or ineffective for long term behavior change. Furthermore, in this study, since participants indicated strong discontent with medical interpreters in hospitals, it is likely that even the medical advice from the doctors give may not be clearly or adequately communicated.

As a result, accounting for different cultural practices, understandings, and knowledge has been shown to be particularly useful to health program planners, who can

work alongside medical professionals and community members to provide relevant information supplemented with other health education programs in the community with considerations for specific community characteristics. This concept of community participation has been applied in other fields but is not widely utilized for many vulnerable or marginalized groups with significantly demonstrated health inequalities such as refugees (Campbell & Jovchelovitch, 2000). For example, in this study, most of the participants who rated their health "fair" or "poor" also reported little to no literacy or English proficiency, so it is likely informational brochures, mailed fliers, or other written messages the Bhutanese refugees mentioned receiving are consistently overlooked. Studies involving other refugees in the US have also found that English proficiency correlates with health, so information regarding health issues should be conveyed appropriately and relevantly (Brown, Schale, & Nilsson, 2010).

Another avenue to disseminate health information can be through existing networks, as seen in this community, through informal learning or direct observation of the "role models" in the community. Observational learning or modeling of health behavior change has been used as a framework for various types of health promotion programs, and with validated techniques and trained leaders, can increase self-efficacy and improve the health of communities which rely heavily on social support (Balcázar et al., 2010; Latham & Saari, 1979). Modeling health behavior based on the abilities of the community, for example, demonstrating examples of health management in-person rather than giving printed material to a population with low literacy levels, can be effective for community health improvement. Overall, understanding the pathways in

which the community obtains, retains, and applies health information can also guide program planners to find appropriate ways to integrate program components to enhance existing channels of health communication in the community, such as through social ties and informal networks.

Second, building on these social networks, especially in close, communal societies can be especially effective in participant recruitment, retention, and long-term program impact. The importance of strong ties can help build community capacity, improve access to existing resources, and increase willingness to participate in health promotion programs in various types of communities (Minkler, 2005). Research has shown community ties and social support are helpful with coping strategies during resettlement, and group-based program designs have shown to be effective with Bhutanese refugee women in previous studies (Vang et al., 2014; Mitschke et al., 2013). For refugees, due to a collective history of hardship and shared migration experiences, as well as resettlement together in the US, refugee groups can develop close bonds and rely on each other for social support. Establishing trust and rapport needed to introduce new health programs from an outside organization or agency can be best initiated through community support with trusted members, leaders, and organizers which have an understanding of the group and can instruct appropriate and convenient meeting places, times, and strategies for health promotion.

Third, having a safe, shared space for community members to voice their concerns can be beneficial for both community members and program planners. For community members, it can be a way to express needs, learn from one another, and

create or strengthen bonds with others. These discussion groups can also help program planners gain an inside perspective on community issues, tailor programs based on identified health needs, and implement culturally sensitive elements into program development alongside the community. A similarly designed community health workshop in another Bhutanese refugee study proved to effectively increase sense of belonging, social capital, and health promotion (Im & Rosenberg, 2015). Though this strategy may not be widely used in the US, especially among resettled refuges, available data on health discussion groups in minority communities in other countries have uncovered various types of health behaviors, motivations, and program recommendations which may have otherwise gone unnoticed through other methods (Bell et al., 2017; Markham et al., 2014; Rachlis et al., 2016). The Bhutanese refugees in this study already had access to communal shared spaces to little or no cost, and these can be reserved and utilized for future health discussions.

Finally, as observed by participants in this study, training community members to become community health workers or advocates has several advantages to improving community health. The benefits of involving community health workers has been well-documented in health disparities research (Krok-Schoen, Weier, Hohl, Thompson, & Paskett, 2016; Wallerstein & Duran, 2006). Community health workers can serve as representatives of local culture and have ties both within the community and with outside resources, acting as a connector or liaison to health services (Krok-Schoen et al., 2016; Wallerstein & Duran, 2006). The bilingual and bicultural nature of community health workers can help in the implementation of relevant health programs. These

programs can also be delivered through appropriate channels in order to build on community members' strengths and improve their health outcomes (Swider, 2002). While the few community leadership training programs for Bhutanese refugees have shown to be beneficial in increasing knowledge, access, and skills in improving health behaviors, more studies are needed which utilize a community health worker model particularly in resettled refugee groups (Im & Rosenberg, 2015; Mitschke et al., 2013; Subedi et al, 2015; Yun et al., 2015). For other vulnerable and ethnic minority groups, trained community health worker programs have shown to be cost-effective and have consistently proven to be extremely successful in improving health, building social support, and bridging community members with existing services (Shediac-Rizkallah & Bone, 1998; Swider, 2002; Israel et al., 2010, Krok-Schoen et al., 2016).

Participants in this study were enthusiastic about the potentials of their community and showed very positive community support for future health promotion and program implementation. Some participants became emotional discussing their concerns and being able to share their stories of hardship throughout their migration and resettlement and expressed appreciation in having their voices heard for the ideas on helping their community. After one group discussion, participants described gatherings in the refugee camps in Nepal, and noted how this group discussion was the first time since coming to the United States. Immediately following the focus group, they spoke about organizing another "women's group" in the near future.

The positive response to community involvement in health promotion and detailed recommendations from the participants in this study shows the strong potential

for success in community engagement with health program implementation. Having appropriate representation and assistance for community health needs can be advantageous for recruitment and retention in health program participation, increase community members' knowledge, awareness, and utilization of existing services, and ultimately significantly improve long-term health. The major recommendations by the community to improve health for Bhutanese refugees in this study demonstrated their ability to draw upon their strengths and highlight specific health needs with proposed solutions. This allowed for a valuable perspective on ways to incorporate community-specific and culturally appropriate health programs in the future to improve health care outcomes for vulnerable groups.

Limitations

The limitations for this study included a relatively small sample size of a specific refugee group. However, collecting community data and generating a needs assessment of a group with collective experiences, communal culture, and close social ties may be similar to other refugee or vulnerable groups in the United States. For example, many vulnerable groups suffer from limited access to health resources and poor health conditions. Some findings from the interviews revealed specific health concerns of the women in the community, who were the majority of the participants. They made recommendations to address these concerns, including having community discussion groups and community advocates. More research is needed to gain detailed descriptions on program recommendations to present various needs of the community while taking to account multiple social and demographic factors.

CHAPTER V

CONCLUSIONS

This research is an exploratory study on the perception of health experienced by the Bhutanese refugee community of Worcester, Massachusetts. Bhutanese refugees are one of the largest resettled refugees group in the US, and have continuously faced health disparities throughout their lives. Existing data on Bhutanese refugees is limited, and health researchers have emphasized the growing need to gain an understanding of community factors which contribute to health outcomes among this group (Misra et al., 2015). Thus, it has become increasingly important to understand their disadvantaged health situation, as they are currently understudied. The multiple factors influencing the health status of this community is not thoroughly understood, especially by those in the public health field. Much can be learned from speaking with the community directly and utilizing their input for developing future relevant health programs. A qualitative approach to understand health perceptions and program recommendations among these groups can significantly add in-depth information to prioritize community needs and strengthen community assets.

Summary of Major Findings

Chapter II focused on the major risk factors and existing health promotion programs found in Bhutanese refugee populations in the United States through a systematic literature review. This review aimed to address gaps in knowledge regarding existing research and studies on Bhutanese refugees, which has not previously been

examined in detail. Data revealed specific factors needed to take into account for health research with Bhutanese refugees, including the role of religious attachment, low rates of preventive screening, importance of language barriers and environmental stressors of newly resettled refugees. Understanding the components to various types of studies on Bhutanese refugee groups can help guide future research towards culturally relevant approaches in other vulnerable groups, as well. Underrepresented groups can benefit by researchers identifying factors which pay a role in a community's health. This, in turn, can increase knowledge, social support, and recruitment and retention in research and health programs.

The major health problems and barriers to health care as perceived by local community members were described in Chapter III. Emerged themes included 1) past experiences influencing present health behaviors, 2) institutional barriers to health, 3) social and cultural barriers to health, and 3) cultural conceptualizations and stigmatization of mental health and women's health. This chapter aimed to present health barriers and perceptions of health directly from the perspective of the community. This is especially important as it shapes community members' views on health behaviors, access, and utilization. Engaging the community in conversations about health needs is a strategy which continues to be underutilized, though it can uncover in-depth information about vulnerable groups which may be otherwise difficult to obtain. Through qualitative research this chapter detailed the current situation of Bhutanese refugees in the United States, including their personal and social context and its

influence on health behaviors, the prominent barriers experienced with the health care system, as well as meanings ascribed to various elements of health.

Chapter IV described community recommendations for relevant programs and health promotion efforts. Major themes included 1) increase access to health information, 2) utilize existing social support from community, 3) implement community health discussion groups, and 4) train and employ community health advocates. Participants highlighted specific health needs with proposed solutions to improve overall health for the community. By giving a voice to the community and a platform to express their concerns, data from this chapter allowed for a valuable perspective on ways to incorporate community-specific and culturally appropriate health programs. Both Chapter III and Chapter IV aimed to address gaps in existing research on general health needs and concerns of Bhutanese refugee populations through a public health perspective. Health outcomes can be vastly improved by listening to community members' perceptions, which ultimately shed light on significant health concerns and factors which influence their health status. This strategy can be applied to other populations to improve positive health outcomes and promote healthy lives for disadvantaged populations.

Discussion

The findings from this study can be used to better understand the contributing factors influencing health disparities among refugee groups in the United States, with a particular emphasis on Bhutanese refugees in central Massachusetts. In addition, findings can provide general guidelines for community health promotion applicable to

broader marginalized groups based on strategies to alleviate common barriers. Limited research exists focusing the interrelatedness of refugee health disparities at various ecological levels as well as perceptions and strategies to improve health among these groups. Figure 3 addresses the major implications of this study's findings through a community health development framework at the social ecological levels of individual, community, and system level. These steps towards community health improvement draw upon the principles of community health development, which is an approach that previous studies have not applied when addressing health promotion of vulnerable groups. This approach can result in significant long-term benefits to both the community and broader society.

Although findings organized in Figure 3 are based on three socioecological levels of a modified Social-Ecological Model (McLeroy et al., 1988), which include individual, community, and system levels, the components are not mutually exclusive with defined boundaries; rather, they are interconnected and impact one another to produce long-term benefits and outcomes to the community as a whole. The program recommendations by the community at each level encompassed a broad range of ideas that could significantly improve community health if adequately addressed through the community health development framework. Utilizing a community health development approach can lead to actions which seek to actively and directly address the health needs and recommendations for programs as illustrated by the community. Finally, the last column displays the potential long-term benefits and health outcomes at each level, when integrating community health development strategies. These are connected by double

sided arrows representing the multiple, simultaneous impact that effective health programs have when targeting more than one level of influence.

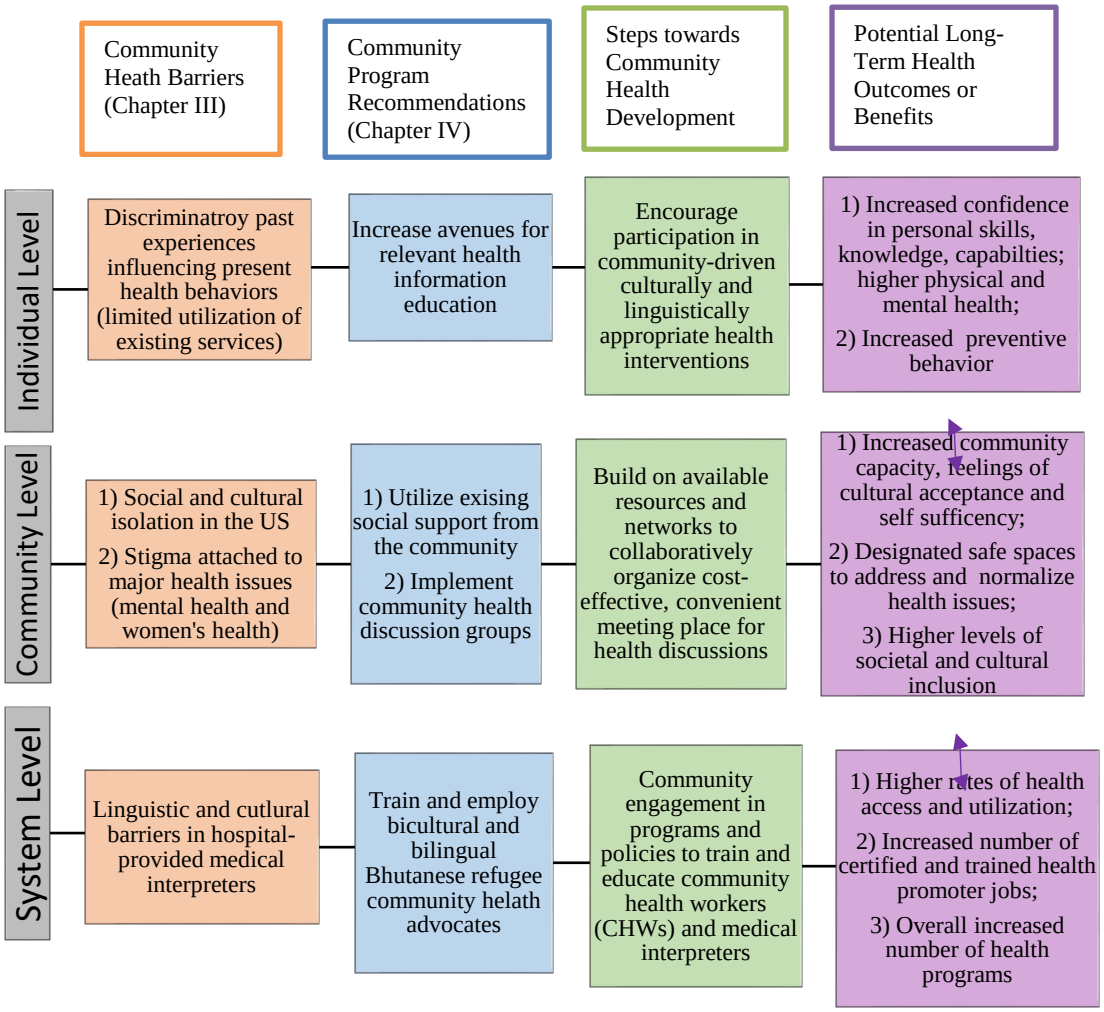

Figure 3. Summary and Implications of Major Findings

Individual level. At the individual level of the social-ecological model, one of the major health barriers discussed with participants was their negative health experiences in the camps, which led to an avoidance of seeking health care in the camps unless the situation was an emergency or required urgent, immediate attention. This

health behavior was carried over into life US in which health was only sought on an as-needed basis, thus limited preventive care and exposure to health promotion and education. While existing research have similarly found low levels of accessing health services among refugees (Palinkas et al., 2003; Mitschke et al., 2003), in-depth knowledge of contextual factors contributing to barriers to health care access in other refugee groups is extremely limited (Morrison et al., 2012). There is a continuous emphasis on the growing need to introduce health promotion strategies which address a community's unique health concerns in order to improve knowledge of general health and increase health care access and utilization (Morrison et al., 2012; Asgary & Segar, 2011; Wong et al., 2011). However, studies focusing on health improvement at the individual level, such as targeting beliefs, attitudes, and behaviors, rarely explore perceptions on health and the impact of previous health services in a host country or country of origin.

Participants in this study also indicated limited avenues for obtaining health information (Chapter IV). Opening additional channels for relevant health education in the community is one way which could significantly improve health, which has shown to be effective in other studies with vulnerable communities in various regions globally (Altman, Nunez de Ybarra, & Villablanca, 2014; Croager, Eades, Pratt, & Slevin, 2010; Wang et al., 2014). Steps towards community health development for this issue may encourage community participation in culturally and linguistically appropriate health interventions specifically geared toward identified health problems and perceptions. As a result, at the individual level, there can be increased confidence in skills, knowledge and

capabilities on improving health. Other research targeting Bhutanese refugee mental health has demonstrated that having a deeper understanding of health and taking action towards positive change, particularly in mental health, can be beneficial to the entire community (Mitschke et al., 2013; Subedi et al, 2010). Having adequate information on important health concerns can increase physical and mental health, as well as preventive behaviors. At the individual level, this study adds an important factor of contextual influences on current attitudes and health behaviors, largely based on one's previous social position in society. This is essential to consider as it can lead to an underutilization of existing services and insufficient health information distributed among community members.

Community level. At the community level, participants in this study indicated feelings of social and cultural isolation in the United Sates, as well as persistent stigma attached to major health concerns, leading to untreated mental health and women's health issues (Chapter III). However, previous research focusing on marginalized groups has generally overlooked the contribution of connections to outside society, and instead focus on expanding within-community social networks or emphasize the need for acculturation into mainstream society (Burnett & Peel, 2001; Asgary & Segar, 2011). Though all of these are significant, the concept of mutually beneficial relationships among a marginalized community and the broader society as an element for improving health and preventive behavior has been understudied in the literature. This issue is especially important, as having connections to outside communities has been proven to be advantageous to exchange ideas, interests, and resources for both new community

members and the host society (Gaertner et al., 1999). Bringing these issues to an open discussion setting and utilizing the existing social support found in the Bhutanese refugee community was one of the prominent recommendations for managing these health concerns (Chapter IV). Thus, community health development at this level could take advantage of available resources and networks already in the community to collaboratively organize a cost-effective, convenient meeting place for health discussions. Shared communal spaces available for little to no cost already exist in this target community, and are commonly available in many other communities as seen through public institutions such as religious centers, libraries, and meeting rooms in larger facilities. The long-term benefits of building capital and connections have been shown in previous research to significantly increase community capacity and self-sufficiency, for the continuation of long-term community organizing (Minkler, 2012). Moreover, members in the community are likely to have increased feelings of cultural acceptance through the normalization of stigmatized health issues discussed in a safe space, a strategy which has helped other groups in previous studies (Knifton et al., 2010). Finally, another long-term benefit would be lower levels of social isolation by increasing avenues for obtaining resources and information from outside organizations or agencies. Few studies focusing on refugees highlight the importance of community discussion groups as a setting which can significantly impacting health promotion and information dissemination for capacity building, as well as a safe space to address both social isolation and stigma in health issues among a highly vulnerable community. At the community level, this study emphasizes the need for decreased isolation through this

form community health development, which can directly influence positive health behaviors through bringing important health topics into an open forum and reducing stigma attached to sensitive health issues.

System level. At the system level, participant discussions focused on the low cultural competency or cultural sensitivity from interpreters provided by medical institutions (Chapter III). Other research has similarly shown that system level barriers are important to consider when implementing programs to improve the health of refugee groups (Asgary & Segar, 2011; Wang et al, 2006). While previous studies have demonstrated various system level or institutional barriers to health in minority groups involving issues with interpreters (Asgary & Segar, 2011), the problems with medical interpreters found in this study further revealed health inequalities in refugees. System level health barriers among the community in this study went beyond issues with medical translation, but also represented of cultural discrimination which can lead to misinterpretation, misdiagnoses, and mistrust. The lack of effective interpreters also revealed the limited number of opportunities for Bhutanese refugees to become trained and employed within the medical system, which can ultimately inhibit their abilities to navigate the complexities of health care in the US. To feel more capable at the system level, participants strongly recommended health programs which aimed to employ knowledgeable bicultural and bilingual community advocates, so that their needs could be adequately met and their voices could be heard (Chapter IV). However, community health workers, as suggested by the Bhutanese refugee community, have been consistently proven to be a significant asset to vulnerable communities, and are able to

assist in various aspects of system level barriers through health care communication and navigation (Swider, 2002; Wallerstein, 2006; Rosenthal et al., 2014; Krok-Schoen et al., 2016).

In community health development, system level programs addressing community advocacy concerns could train and educate Bhutanese refugee community health workers. Community health workers among vulnerable groups may serve also as cost-effective community liaisons, who can partner with clinics and hospitals to increase resource knowledge and availability to improve health in the community (Rosenthal et al., 2014). Additionally, some community health workers may also be trained and certified as medical interpreters which would increase the number of Bhutanese refugee interpreters in the hospital system. Research involving other minority groups, such as Latinos, has found that having culturally competent medical interpreters is needed to help both the community and medical professionals provide more effective care (Baig et al., 2014; Flores, 2005; Timmins, 2002). The benefits at the system level would be higher rates of health access and utilization, as well as an increased number of certified and trained health promoters for Bhutanese refugees, as there are currently few known Bhutanese refugee community health workers in the Worcester area. With enough advocacy and representation, this could potentially impact local policy in health institutions. For example, this can include increased patient centered health programs at hospitals, establishing programs at health facilities to include refugee health concerns, and creating more health jobs for local Bhutanese refugee residents.

Implications for Research, Practice, and Policy

There are several implications for research, practice, and policy for future studies with refugee groups based on this study. First, when conducting research with vulnerable refugee groups, the social ecological model and community health development approach are valuable tools for obtaining a holistic understanding of the community and are underutilized in health studies. Incorporating individual, community, and system level concerns, and acknowledging the interwoven health needs from multiple simultaneous levels has been shown to produce potentially highly effective health programs but has not been commonly used for public health research with refugees (Cook, Purdie-Vaughns, Meyer, & Busch, 2014; Baron et al., 2014; Stokols, 1996). In line with this study's findings, other research has shown that sensitive personal information can only be obtained through speaking directly with the community, gaining their perspective, and listening closely to their concerns (Bloch et al., 2014; Wallerstein & Duran, 2006). This study takes this a step further by uncovering the value of health perceptions and conceptualizations based on past historical context, social and cultural influences on health care utilization, and the inclusion of the voice of the community in recommendations for overall health improvement. Therefore, it is imperative that research includes the consideration of community perceptions in both the health needs as well as recommendations for health improvement in order to sufficiently address multiple levels of health influence on behavior and steps towards community health development in these groups.

Second, in practice, the community perspective is necessary and invaluable. Community participation and input is essential in developing health programs, and understanding health needs while working collaboratively to implement a solution can produce viable and lasting positive health outcomes (Minkler, 2012). While community members do provide significant health information, it is also important to incorporate other stakeholders, health care providers, community leaders and key persons to gain a well-rounded view of the community. Recent studies have also demonstrated that obtaining multiple perspectives on community health needs can help to reduce disparities and increase the likelihood for long-term effectiveness (Urben et al., 2015; Betancourt, 2016; DeVoe et al., 2016). However, there are limited studies which emphasize community members as key sources for problem identification and program development strategies throughout the entire research process. As seen in this study, complementary perspectives found in discussion groups and conversations with community leaders can help obtain valuable insight on both the immediate and prioritized health needs, as well as recommendations and support for community health development. This is essential for long-term behavior change and maintenance and an overall positive health status for a population based on the community health development approach (Burdine et al., 2010). Obtaining and integrating input from multiple views on health issues are factors which are not readily utilized in practice but can produce highly effective public health programs.

Third, it can be seen that globally, refugees experience various health disparities and there is an urgent need to improve policy to incorporate vulnerable groups such as

refugees (Edge & Newbold, 2013; Langlois, Haines, Tomson, & Ghaffar, 2016; Patil, Maripuu, Hadley, & Sellen, 2015). Recent increasingly restrictive US policy against refugees and migrant flow into the country further demonstrates the urgency to prioritize the health and well-being of vulnerable groups in the United States. Policies which prohibit refugees from the opportunity to migrate to areas which could improve their health and longevity is not only detrimental to the refugees, but also the broader society (Vang and Trieu, 2014; Aday 2002). While major changes in policy can be difficult to achieve, there are still factors which should be taken into consideration which can influence program or policy development, or can affect refugee groups on a smaller scale which may still significantly impact community health. For example, feasibility of sustainable programs are largely depending on the community's existing resources, funding, financial constraints and partnership opportunities. As found in this study, determining the resources of the community, the willingness for participation and retention in programs, as well as the potential for health behavior maintenance, all which influence policy in the long-term, can be effectively discerned through conversations and interactions with the community. Obtaining direct input from multiple perspectives, including community members, leaders, stakeholders, partners, and potential partner organizations can also help determine the capabilities or capacity, and strengths of the community. This, in turn, can provide information for program development which ultimately can influence general policy and practice in the community. Rather than only obtaining evidence from medical personnel, as seen in other health studies, there is much value in community perspectives on health needs that can significantly impact the

societal structure and health care system of which they are a part (Shediac-Rizkallah & Bone, 1998; Felix et al., 2010).

Overall, to successfully implement programs, a holistic understanding of the community is needed. This includes knowing and understanding the health needs from the community perspective, and working with the community to implement sustainable solutions. This study demonstrates that using a social ecological model and community health development approach are strong tools for gathering an in-depth community assessment gathered from multiple sources and affecting various levels of influence. Using these strategies to create and design programs can significantly build community capacity, have effective program implementation and impact long term health change for vulnerable groups in the United States.

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APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

1. How old are you (in years)? _____
    a. (Note: This study will only include adults over 18)
2. Where were you born? _____
3. Where did you live before coming to the United States?_____
4. Have you lived in a refugee camp? Yes/ No
    a. If yes, where?_____
        i. For how long did you live in a refugee camp?_____
5. How long have you lived in the United States? _____
6. How long have you lived in Worcester?_____
7. If you speak English, how much do you speak? (Circle)
    a. None
    b. Little
    c. Some
    d. Fluent
8. Have you ever attended school? Yes/No
    a. If so, how many years?_____
9. I would like to know more about your employment before coming to the United States. Did you have a job or profession where you used to live? Yes/No
    a. If yes, what was your job?_____
10. Do you work now? Yes/No
        i. If yes, what is your job?_____
11. What is your household monthly income?_____
12. Do you have health insurance? Yes/ No
13. In general, would you say that your health is:
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

APPENDIX B

GENERAL FOCUS GROUP GUIDE

Opening

1. Please introduce yourselves, what is your name (pseudonym if they do not want to give name)? How do you feel about life in Worcester?

System Level

2. How is getting health services here different than in Nepal/refugee camp/Bhutan?
3. There are different ways people address their health, such as routine check-ups, preventative screening, or others. Is this common in the Bhutanese community? Where do you, or people you know, go in Worcester for help or advice for health issues?
4. What are some of the difficulties in going to health-related places (clinics, hospitals, etc) and getting the services and information you need for a health problem? Does your status or role (as a refugee) change the way you think about or get health care compared to your life in Nepal/refugee camp/Bhutan?
5. Are there any health services that you feel Bhutanese refugees here need but do not have?

Community Level

6. What are some organizations that help refugees when they have health concerns?
7. Other than those who work at organizations that you mentioned, are there individuals here (in focus group or in Worcester/ surrounding areas) that help Bhutanese refugees find out about and/or get to health services?
8. If you could design a program to help refugees in the Bhutanese community have better health, what would be the top two most important factors to include?

Individual Level

9. How has the process of adjusting to a new life and/or culture gone for you? What about others that you know? Do you think others are having similar or different experiences adjusting?
10. How is mental health seen or addressed in your culture?
11. What are the most important health concerns for you and/or your family?

Closing

12. Are there any other things important to you about Bhutanese refugee health that we haven't asked you about? Please feel free to tell us about additional thoughts or ideas you have.

APPENDIX C

KEY INFORMANT INTERVIEW GUIDE

1. To begin, can you tell me a little bit about you and your role in this community? How long have you lived here?
2. In general, how would you rate health {and quality of life} of the Bhutanese community?
3. In your opinion, has health and quality of life in the Bhutanese community of Worcester changed at all in the past few years? If so, how? Why do you think that is?
4. What barriers, if any, exist to improving health of Bhutanese community?
5. In your opinion, what are the most critical health issues facing the Bhutanese community?
6. What needs to be done to address these issues?
7. In your opinion, what else will improve health and quality of life among this community?
8. Is there someone (who) you would recommend that also might be helpful to talk about community health issues for this study?
9. Is there anything you would like to add?